Crossroads Chiropractic & Acupuncture

9320 Olde Eight Road, Northfield Center, OH 44067
(330) 467-0508 (p) ~ (330) 467-0140 (f)

Confidential Patient Information

Date: _____

Patient Name: _____ Chief Complaint: _____

Address: _____ Primary Phone: _____

City: _____ Zip: _____ Email: _____

Date of Birth: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Insurance Policy Holder **(if different than above)**: _____ Policy Holder Birthdate: _____

Is your present condition the result of an auto collision, work-related injury or other personal injury? ___ Yes ___No Name of attorney if applicable: _____

Primary Care Physician: _____ (Note: May we send your health information to this provider **Y / N**)

Emergency Contact: Name _____ Phone # _____ Relationship _____

Have you ever been under Chiropractic Care? **Y** **N** If so, please provide name of doctor: _____

Have you had any **SPINAL** X-Rays / MRI's / CT's taken in the last year? **Y** **N** If so, where? _____

Spinal surgeries? **Y** **N** Year _____ Describe: _____

Do you have a pacemaker or defibrillator? **Y** **N** Have you ever had any Hip or Knee Replacements? **Y** **N**

What medications are you taking? (Check ALL that apply): Pain Killers ____ Insulin ___ Cholesterol Meds ___
Blood Pressure Meds ___ Muscle Relaxers ___ Birth Control ___ Supplements ___ Other: _____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to Crossroads Chiropractic & Acupuncture all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer, and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

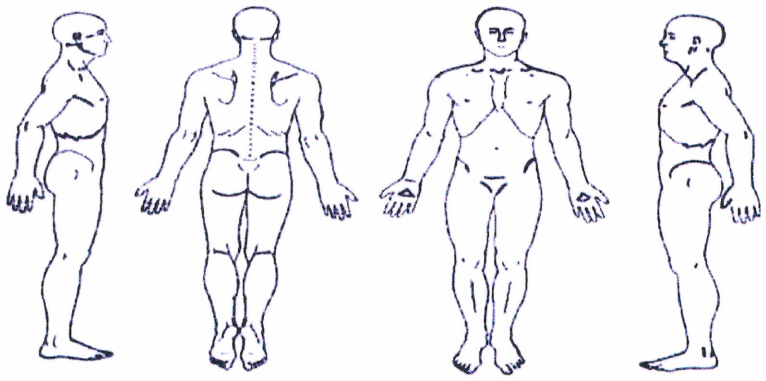
_____ _____
Signature of Insured / Guardian Date

Crossroads Chiropractic & Acupuncture
9320 Olde Eight Road, Northfield Center, OH 44067
(330) 467-0508 (p) ~ (330) 467-0140 (f)

CASE HISTORY

Name: _____

1. Indicate with a **CIRCLE** or **X** on the drawings below where you have pain/symptoms.



2. How often do you experience your symptoms?
   - ☐ Constantly (80-100% of the time)
   - ☐ Frequently (50-79% of the time)
   - ☐ Occasionally (25-49% of the time)
   - ☐ Intermittently (1-24% of the time)

3. How would you describe the type of pain?
   - ☐ Sharp
   - ☐ Tingly
   - ☐ Shooting w/motion
   - ☐ Throbbing
   - ☐ Numb
   - ☐ Achy
   - ☐ Stiff/Tight
   - ☐ Stabbing w/motion
   - ☐ Dull
   - ☐ Burning
   - ☐ Diffuse (spread out)
   - ☐ Other: _____

4. How are your symptoms changing with time?
   ____ Improved ____ Gotten Worse ____ Stayed the same since it began

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?
   0 1 2 3 4 5 6 7 8 9 10 (Please circle)

6. How much has the problem interfered with your work?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐ N/A

7. How much has the problem interfered with your social activities?
   ☐ Not at all ☐ A little bit ☐ Moderately ☐ Quite a bit ☐ Extremely ☐ N/A

8. How long have you had this problem? _____

9. How do you think your problem began? _____

10. Who else have you seen for this problem?_____

11. What makes your problem WORSE?_____

12. What makes your problem BETTER?_____

13. Were you referred to our office by anyone? _____

14. Any other Musculoskeletal problems? ____No ____Yes Neurological problems? ____No ____ Yes

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

crossroads
chiropractic
& acupuncture

9320 Olde Eight Road
Northfield Center, Oh 44067
www.crossroads-chiro.com

Electronic Health Records Intake Form

In compliance with requirements for the government EHR incentive program

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

CMS requires providers to report both race and ethnicity

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian)
Native Hawaiian or Pacific Islander / Other / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

☐ **I choose to decline receipt of my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)*

Patient Signature: _____ Date:_____

For office use only

Height: _____ Weight:_____ Blood Pressure:_____/_____

Crossroads Chiropractic & Acupuncture
9320 Olde Eight Road, Northfield Center, OH 44067
(330) 467-0508 (p) ~ (330) 467-0140 (f)

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this, we believe communication is the key. There are often topics that are hard to understand, and we hope this document will clarify those issues for you. Please read the following, and if you have any questions, please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your doctor of chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by a physician at Crossroads Chiropractic & Acupuncture, I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

- **Women Only:**

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation. *(Circle one above)* *(Circle one above)*

- **Missed Appointments:** Please call the office as soon as possible if you will need to reschedule your appointment.

Any **MASSAGE APPOINTMENT** that is not canceled **24 hours prior** to scheduled appointment will be charged **$35**.
Three (3) late cancellations for massage in 1 calendar year will result in a suspension of those services.

- **Outstanding Balances:**

There will be an **annual 18% interest fee** charged to any balance **30 or more days outstanding**.

- **Consent to Evaluate and Treat a Minor:**

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

- **Communications:**

In the event we would need to communicate your healthcare information, to whom may we do so?

Spouse/Partner: _____

Children: _____

Others: _____ No one: _____
May we leave messages regarding your personal healthcare information on any answering device? Yes [ ] No [ ]
May we contact you via email? Yes [ ] No [ ]

- **Acknowledgement**

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____ Signature: _____
Date: _____