ULERY CHIROPRACTIC

SPINE, SPORT & REHAB

Todd Ulery, DC, CCSP

Certified Chiropractic Sports Physician

109 Crossroads Road, Suite 206
Scottdale, PA 15683
724-887-4661
www.ulerychiropractic.com

PATIENT INFORMATION & CONDITION

PERSONAL INFORMATION

TODAY'S DATE _____ ☐ MARRIED ☐ SINGLE ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

NAME _____ EMAIL _____

BIRTH DATE _____ AGE ____ GENDER M / F SOCIAL SECURITY NUMBER _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ CELL PHONE _____ WORK PHONE _____

OCCUPATION _____ ☐FULL TIME ☐ PART TIME ☐RETIRED ☐UNEMPLOYED

EMPLOYER _____ EMPLOYER PHONE _____

EMPLOYER ADDRESS _____ STATE _____ ZIP _____

ARE YOU A STUDENT NO / YES ☐ FULL-TIME ☐ PART-TIME SCHOOL NAME _____

SPOUSE NAME _____ SPOUSE DATE OF BIRTH _____ SPOUSE PHONE _____

SPOUSE OCCUPATION _____ SPOUSE'S EMPLOYER _____

EMERGENCY CONTACT NAME & RELATIONSHIP _____ PHONE _____

HOW DID YOU LEARN ABOUT US _____

INSURANCE INFORMATION

INSURANCE _____ POLICY/ID # _____ GROUP# _____

POLICY HOLDER NAME _____ DATE OF BIRTH _____ PHONE _____

MEDICAL INFORMATION

PRIMARY CARE PHYSICIAN _____ PHONE _____

ADDRESS _____ STATE _____ ZIP _____

CONDITION

IS YOU CONDITION RELATED TO

☐AUTO ACCIDENT ☐WORK RELATED ACCIDENT ☐ ACCIDENT IN SOMEONE'S HOME

☐ ACCIDENT ON PREMISE OF SOMEONE'S BUSINESS ☐OTHER ACCIDENT

☐ NON ACCIDENT ☐JUST SEEKING GENERAL GOOD HEALTH

DATE SYMPTOMS/ INJURY/ ACCIDENT OCCURRED _____

DESCRIBE YOUR CONDITION(S) AND PURPOSE OF TODAY'S APPOINTMENT _____

_____

_____

DESCRIBE YOUR PAIN ☐ BURNING ☐ SHARP

☐DULL ☐ ACHE ☐NUMB/TINGLING

RATE YOUR PAIN

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

IS THE PAIN ☐CONSTANT or does it ☐COME and GO

DOES THE PAIN INTERFERE WITH YOUR

☐WORK ☐SLEEEP

☐DAILY ROUTINE ☐RECREATION

ARE ANY OF THE FOLLOWING PAINFUL TO PERFORM

☐SITTING ☐STANDING ☐WALKING

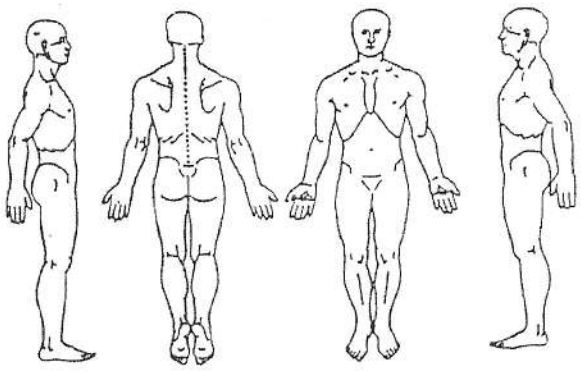
☐BENDING ☐LYING DOWN

Have you missed work or school as a result of your injuries

☐NO ☐ YES

PLEASE MARK – XXXXXX FOR PAIN

OOOOO FOR NUMBNESS



WHAT CAUSED YOUR PAIN _____

WHAT AGGRAVATES YOUR PAIN_____

WHAT RELIEVES YOUR PAIN _____

HAVE YOU EVER HAD THE SAME OR SIMILAR CONDITION IN THE PAST ☐ NO ☐YES -- DATE _____

IF YES PLEASE DESCRIBE _____

_____

PLEASE LIST ANY OTHER HEALTHCARE PROVIDERS YOU'VE SEEN FOR THIS CONDITION AND WHEN YOU LAST SAW THEM

NAME	TYPE OF PRACTICE	DATE OF LAST VISIT
_____	_____	_____
_____	_____	_____

SYMPTOMS

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS

☐HEADACHE	☐CLUMSINESS	☐TINGLING LEGS/FEET	☐NERVOUSNESS	☐NUMBNESS LEGS/FEET
☐LOSS OF MEMORY	☐SLEEPING PROBLEMS	☐CONSTIPATION	☐FAINTING	☐SHARP SHOOTING PAIN
☐HANDS COLD	☐BUZZING IN EARS	☐SHORTNESS OF BREATH	☐PAIN ARMS/HANDS	☐NECK PAIN
☐NUMBNESS ARMS/HANDS	☐TENSION	☐CHEST/RIB PAIN	☐DIFFICULTY SWALLOWING	☐EARS RING
☐COLD SWEATS	☐LOSS OF SMELL	☐LOSS STRENGTH LEGS	☐HEAD SEEMS TOO HEAVY	☐BACK PAIN
☐IRRITABILITY	☐BURNING MUSCLE PAIN	☐DIARRHEA	☐TINGLING ARMS/HANDS	☐LOSS OF BALANCE
☐LOSS STRENGTH ARMS/HANDS	☐LIGHT BOTHERS EYES	☐NECK STIFFNESS	☐NAUSEA	☐FATIGUE
☐DIZZINESS	☐FEET COLD	☐FACE FLUSHED	☐PAIN IN LEGS/FEET	☐JAW PAIN
			☐FEVER	

HAVE YOU EXPERIENCED ANY CHANGE TO:

☐EYES (SIGHT) ☐EARS (HEARING) ☐NOSE (SMELL) ☐MOUTH (TASTE) ☐BLADDER ☐BOWELS ☐SLEEP ☐EMOTION ☐APPETITE

PLEASE EXPLAIN _____

_____

HAVE YOU BEEN IN OUR OFFICE BEFORE ☐ NO ☐YES

DO YOU SMOKE ☐ NO ☐ YES -- # OF PACKS_____ HOW OFTEN_____

DO YOU DRINK ALCOHOL ☐ NO ☐ YES -- # OF DRINKS_____ HOW OFTEN_____

DATE OF LAST PHYSICAL EXAM _____

LIST ANY PREVIOUS ACCIDENTS OR INJURIES (WORK, AUTO OR PERSONAL)

1. _____DATE _____
2. _____DATE _____
3. _____DATE _____

SURGERIES / HOSPITALIZATIONS AND DATES

1. _____DATE _____
2. _____DATE _____
3. _____DATE _____

ALLERGIES _____

CURRENT MEDICATIONS AND REASON TAKING _____

_____

PLEASE INDICATE IF YOU HAVE EVER HAD OR IF YOU NOW HAVE ANY OF THE FOLOWING MEDICAL CONDITIONS

☐AIDS/HIV
☐ANEMIA
☐ANOREXIA
☐ARTHRITIS
☐ASTHMA
☐BLEEDING DISORDER
☐BREAST LUMP
☐BULIMIA
☐CANCER _____
☐CHEMICAL DEPENDENCY
☐DIABETES
☐EPILEPSY
☐FRACTURES_____
☐HEART DISEASE
☐HEPATITIS
☐HERPES
☐HIGH BLOOD PRESSURE
☐HIGH CHOLESTEROL
☐KIDNEY DISEASE
☐LIVER DISEASE
☐MIGRAINE HEADACHES
☐MULTIPLE SCLEROSIS
☐OSTEOPOROSIS
☐PARKINSON'S DISEASE
☐PINCHED NERVE
☐POLIO
☐PROSTATE PROBLEMS
☐PROSTHESIS
☐RHEUMATOID ARTHRITIS
☐STROKE
☐THYROID PROBLEMS
☐TUMORS/GROWTH
☐OTHER _____

ARE YOU PREGNANT OR ANY POSSIBILTY YOU MAY BE PREGNANT? ☐ YES ☐ NO ☐ UNCERTAIN

I HAVE READ, UNDERSTOOD, AND AGREE TO THE FOREGOING. THE INFORMATION WHICH I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE _____ DATE _____

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PATIENT AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

I, _____ HEREBY AUTHORIZE ULERY CHIROPRACTIC TO USE AND DISCLOSE MY HEALTH INFORMATION IN THE MANNER DESCRIBED BELOW.

1. RELEASE OF EXAMINATION AND TEST RESULTS TO PHYSCIANS, HOSPITALS, AND HEALTH CARE AGENCIES INVOLVED IN MY CARE.
2. I AUTHORIZE ULERY CHIROPRACTIC TO PROVIDE ME COPIES OF TEST RESULTS UPON MY REQUEST AND WILL ASSUME RESPONSIBILTY FOR SAFEGUARDING THIS HEALTHCARE INFORMATION FROM IMPROPER DISCLOSURE
3. I AUTHORIZE ULERY CHIROPRACTIC TO DISCLOSE MY HEALTH CARE INFORMATION AND/OR BILLING INFORMATION TO THE FOLLOWING PERSON WHO IS INVOLVED WITH MY CARE:

   _____

   _____

4. I AUTHORIZE ULERY CHIROPRACTIC TO RECEIVE HEALTH CARE INFORMATION FROM ANY PHYSICIAN OR HEALTH CARE AGENCY DIRECTLY INVOLVED IN MY CARE. THIS APPLIES TO VERBAL, WRITTEN AND ELECTRONIC SUBMISSIONS.
5. THIS AUTHORIZATION IS IN EFFECT UNTIL I REVOKE IT AND I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING ULERY CHIROPRACTIC IN WRITING. I AM AWARE THAT MY REVOCATION S NOT EFFECTIVE TO THE EXTENT OF THE PERSONS THAT I HAVE AUTHORIZED TO USE/OR DISCLOSE MY HEALTH INFORMATION HAVE ACTED IN RELIANCE UPON THIS AUTHORIZATION.

_____ _____

PATIENT SIGNATURE DATE

IF THIS AUTHORIZATION IS SIGNED BY A PATIENT'S PERSONAL REPRESENTATIVE ON BEHALF OF THIS PATIENT, PLEASE COMPLETE THE FOLLOWING:

_____ _____

NAME OF PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

*NOTE THAT THIS FORM MAY BE USED TO DOCUMENT THE FOLLOWING TYPES OF PERSONAL REPRESENTATIVE RELATIONSHIPS: 1) MAKING APPOINTMENTS FOR HEALTH CARE SERVICES 2) DISCUSSION WITH HEALTH CARE PROVIDERS ABOUT ROUTINE TESTS AND TREATMENT (DO NOT REQUIRE INFORMED CONSENT) 3) ACCESS TO MEDICAL RECORDS.

*NOTE THAT THIS FORM ALSO SERVES AS AN ACKNOWLEDGEMENT THAT THE PATIENT HAS RECEIVED OR BEEN MADE AWARE OF ULERY CHIROPRACTIC'S NOTICE OF PRIVACY PRACTICE FOR PROTECTED HEALTH INFORMATION.

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RELEASE OF RESPONSIBILITY

ALL INSURANCE RECIPIENTS

IN THE EVENT OF NON –PAYMENT BY AN INSURANCE CARIIER (HEALTH, AUTO or WORKERS COMP), I TAKE FULL RESPONSIBILITY FOR PAYMENT OF ALL TREATMENT RENDERD BY ULERY CHIROPRACTIC.

BY MY SIGNATURE, I ACKNOWLEDGE THAT IF MY INSURANCE CARRIER DENIES PAYMENT I AGREE TO BE PERSONALLY AND FULLY REPSONSIBLE FOR PAYMENT AND THAT I AM ALSO RESPONSIBLE FOR ANY CHARGES OR BALANCES NOT COVERED BY MY INSURANCE CARRIER.

MEDICARE RECIPIENTS

IN ACCORDANCE WITH THE MEDICARE ACT, SECTION 1842 (1), THIS NOTICE IS TO ADVISE YOU THAT MEDICARE WILL ONLY PAY FOR SERVICES THAT IT DETERMINES TO BE REASONABLE AND NECESSARY UNDER SECTION 1852 (1) OF THE MEDICARE ACT. IF MEDICARE DETERMINES THAT A PARTICULAR SERVICE, ALTHOUGH NORMALLY COVERED, IS NOT REASONABLE AND NECESSARY UNDER MEDICARE PROGRAM STANDARDS, MEDICARE WILL DENY PAYMENT FOR THAT SERVICE.

BY MY SIGNATURE, NOTIFICATION BY MY DOCTOR THAT HE BELIEVES IN MY CASE MEDICARE IS LIKELY TO DENY PAYMENT FOR THE SERVICES RENDERED FOR THE REASON STATED ABOVE. IF MEDICARE DENIES PAYMENT I AGREE TO BE PERSONALLY RESPONSIBLE FOR PAYMENT AND THAT I AM ALSO RESPONSIBLE FOR ANY CHARGES OR BALANCES NOT COVERED BY MY INSURANCE CARRIER.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE

IN OUR OFFICE WE SPECIALIZE IN TREATING THE NEURO-MUSCULOSKELETAL SYSTEM. WE UTILIZE X-RAYS TO HELP INSURE AN ACCURATE DIAGNOSIS AND PROPER TREATMENT PLAN. MANUAL ADJUSTMENTS, ELECTRICAL MUSCLE STIMULATION, ULTRASOUND, CRYOTHERAPY (ICE), MOIST HEAT, INTERSEGMENTAL TRACTION, REHABILITATIVE EXERCISES, AND DIOWAVE LASER ARE UTILIZED IN THIS OFFICE AS PART OF YOUR TOTAL HEALTH CARE.

IF DR. ULERY FEELS THAT YOUR CONDITION CANNOT BE TREATED CHIROPRACTICALLY, A PROPER REFERRAL WILL BE MADE IMMEDIATELY. THEREFORE, WE MUST BE INFORMED OF ANY NEW OR EXISTING PROBLEMS THAT YOU MAY BE HAVING.

I AM FULLY AWARE OF DR. ULERY'S RECOMMENDATIONS FOR CARE AND I AM AUTHORIZING TREATMENT THEREOF.

_____ _____

PATIENT SIGNATURE DATE

_____ _____

WITNESS SIGNATURE DATE