Long Chiropractic Office
4978 Northcutt Place, Dayton, OH 45414
7244 Far Hills Ave. Centerville, OH 45459
(937) 278-7246 (p) ~ (937) 278-5640 (f)

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. Please read the following and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

The chiropractic adjustment, clinical procedures, physical therapy procedures, and rehabilitation exercises are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury, such as fractures, muscular strain, ligamentous sprain, intervertebral disc injury, nerve injury, or stroke. The doctor, of course, will not give any treatment or care if he determines such care may be contra-indicated. It is the responsibility of the patient to disclose any known latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized health care service 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 Long Chiropractic Office, I am granting authorization to proceed with treatment that Dr. Long deems necessary. Furthermore, any additional questions I may have regarding chiropractic treatment will be answered 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)*

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:

To whom may we communicate your healthcare information?

Spouse: _____

Children: _____

Others: _____

No one: [ ]

May we leave messages regarding your personal healthcare information on any answering device?
(i.e. home answering machines or voicemails) Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have read the Notice of Privacy Practices Form (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: _____

AUTOMOBILE ACCIDENT HISTORY

Date of Accident: _____ Time of Accident: _____ A.M. P.M.

State how the Accident happened in your own words:

_____

_____

What type of vehicle were you in? Make: _____Year: _____

Were you driving? **Yes No** Was it your car? **Yes No** If not, whose? _____

Passenger? **Front Back Right Side Left Side** Were you rotated in seat? **Yes/No Rt./Lt.**

Was your head rotated? **Yes/No Rt/Lt.** Were you reclined? **Yes No** Other: _____

Other people in car? **Yes No**

Names:_____

Were they injured? **Yes No**

If yes, please explain: _____

_____

Seat belts on? **Yes No** Shoulder harness on? **Yes No** Position of headrest _____

Was it? **Daylight Night Dark Dawn** What were the weather conditions? _____

What was the posted speed limit? _____ How fast were you going? _____ How fast was the other vehicle going? _____

Did you see the accident coming? **YES / NO**

Did it happen at a/an: **Stop Sign Traffic Light Intersection Highway**

Was your car hit? **Left/Right Front Back Side**

What damage was done to your car? _____

If you struck another car, did you strike it: **Left/Right Front Back Side**

What was the damage to the other car? _____

Was accident report made? **Yes No** Police of: **City: _____ County: _____ State: _____**

Who was ticketed? _____ For what? _____

Did your vehicle strike anything? **Yes No** If yes: **Another Car Sign Tree Other:** _____

Did your vehicle go off the road? **Yes No**

Were you completely conscious after the impact? **Yes No** Do you remember the impact? **Yes No**

Did you hit part of your body during the collision, for example: head on dash, chest on steering wheel? **Yes No**

If yes, which part and how? _____

Describe how you felt (BE SPECIFIC):

- Immediately after the accident: _____
- Later that day/night: _____
- The next day: _____

Did you seek medical help immediately/soon after the accident: **YES/NO**

If yes, how did you get there? **Drove self / someone else drove me / Ambulance / Police / Other** _____

#1 Doctor/Hospitial/Clinic seen: _____

Were you examined? **Yes/No** Did you receive: **X-rays / CT Scan / MRI / Other** _____

Did you receive any treatment? **Yes/No** If yes, what treatment did you receive? _____

What benefit did you receive from treatment? _____

Date of last treatment: _____

#2 Doctor/Hospitial/Clinic seen: _____

Were you examined? **Yes/No** Did you receive: **X-rays / CT Scan / MRI / Other** _____

Did you receive any treatment? **Yes/No** If yes, what treatment did you receive? _____

What benefit did you receive from treatment? _____

Date of last treatment: _____

#3 Doctor/Hospitial/Clinic seen: _____

Were you examined? **Yes/No** Did you receive: **X-rays / CT Scan / MRI / Other** _____

Did you receive any treatment? **Yes/No** If yes, what treatment did you receive? _____

What benefit did you receive from treatment? _____

Date of last treatment: _____

Prior to this accident, were you experiencing or have you ever had symptoms similar to what you are experiencing now? **Yes / No**

If yes, please explain: _____

Have you had any time loss from work? **Yes No** If yes, from _____to _____

The above information is accurate and has been completed to the best of my knowledge:

Patient Signature: _____ Date: _____

Long Chiropractic Office
Personal Injury Policy and Information

Long Chiropractic Office policy requires all Personal Injury Cases be filed under Medical Payment (Med-Pay) from an auto insurance company. If you do not have Med-Pay available you must pay at the time of service or retain an attorney to represent your case. If you need an attorney our office can provide you with the names of several local attorneys that we have good experience working with.

Insurance Information

Your Auto Insurance

Insurance Name_____ Policy #_____

Phone #_____ Claim#_____

Date of Accident_____ Adjuster_____

Full Coverage? YES or NO Med-Pay? YES or NO Amount$_____

Other Parties Auto Insurance

Insurance Name_____ Claim #_____

Phone #_____ Adjuster_____

Health Insurance

Our office must obtain your personal health insurance as back up if no payment were to be issued on your case.

Insurance Name_____

Phone #_____ Group#_____

Subscriber_____ Subscriber ID_____

Subscriber DOB_____ Employer_____

Attorney Information

Attorney _____ Phone#_____

I have read and understand Long Chiropractic's Personal Injury Policy. I understand that I am financially responsible for any and all balances that occur under my account. By signing this policy I am agreeing to its terms.

Patient Name (Print)_____

Patient/Guardian Signature_____

Date_____

Long Chiropractic Office
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RED FLAG QUESTIONNAIRE

NAME _____ DATE _____ AGE _____

Please check the appropriate response. If "yes", please explain. If you are not sure, check the "?" box.

NO	YES	?	
☐	☐	☐	Do you have a past history of cancer?
☐	☐	☐	Have you had any unexplained weight loss?
☐	☐	☐	Does your pain improve with rest?
☐	☐	☐	Are you over 50 years old?
☐	☐	☐	Failure to respond to a course of conservative care (4-6 weeks)?
☐	☐	☐	Have you had spinal pain greater than 4 weeks?

NO	YES	?	
☐	☐	☐	Prolonged use of corticosteroids (such as organ transplant Rx)?
☐	☐	☐	Intravenous drug use?
☐	☐	☐	Current or recent urinary tract, respiratory tract or other infection?
☐	☐	☐	Immunosuppression medication &/or condition?

NO	YES	?	
☐	☐	☐	History of significant trauma?
☐	☐	☐	Minor trauma in person >50 years old?
☐	☐	☐	Do you have osteoporosis (weak bones)?
☐	☐	☐	Are you over 70 years old?
☐	☐	☐	Any history of prolonged use of corticosteroids?

NO	YES	?	
☐	☐	☐	Acute onset urinary retention or overflow incontinence (wet underwear)
☐	☐	☐	Loss of anal sphincter tone or fecal incontinence (bowel accidents)
☐	☐	☐	Saddle anesthesia (numbness in the groin region)
☐	☐	☐	Global or progressive muscle weakness in the legs (legs give out)

COMMENTS:_____
_____
_____
_____
_____
_____

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RELEASE OF INFORMATION

I authorize Long Chiropractic Office to release information pertinent to my case to my insurance company, adjuster, and/or attorney involved in this case; and hereby release Long Chiropractic Office of any consequence thereof.

_____
Patient Name (print)

_____ _____
Patient Signature Date

ASSIGNMENT

I hereby instruct and direct any insurance company and/or attorney to pay by check, made out and mailed directly to Long Chiropractic Office, the professional or medical expenses/benefits allowable and otherwise payable to me under current insurance policy as payment toward the total charges for professional services rendered by Long Chiropractic Office.

_____
Patient Name (print)

_____ _____
Patient Signature Date

FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges incurred at this clinic including any insurance deductible, co-payment and any services rejected by the insurance company.

_____
Patient Name (print)

_____ _____
Patient Signature Date

WELCOME

PATIENT INFORMATION

Date _____

SS/HIC/Patient ID # _____

Patient Name _____
Last Name

_____
First Name Middle Initial

Address _____

City _____

State _____ Zip _____

E-mail _____

Sex ☐ M ☐ F Age _____

Birthdate _____

☐ Married ☐ Widowed ☐ Single ☐ Minor

☐ Separated ☐ Divorced ☐ Partnered for _____ years

Occupation _____

Patient Employer/School _____

Employer/School Address _____

_____

Employer/School Phone (____) _____

Spouse's Name _____

Birthdate _____

SS# _____

Spouse's Employer _____

Whom may we thank for referring you? _____

INSURANCE

Who is responsible for this account? _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Insurance Co. _____

Group # _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with

_____ and assign directly to
Name of Insurance Company(ies)

Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____
Signature of Patient, Parent, Guardian or Personal Representative

_____
Please print name of Patient, Parent, Guardian or Personal Representative

_____ _____
Date Relationship to Patient

PHONE NUMBERS

Home Phone (____) _____

Cell Phone (____) _____

Best time and place to reach you _____

IN CASE OF EMERGENCY, CONTACT

Name _____

Relationship _____

Home Phone (____) _____

Work Phone (____) _____

ACCIDENT INFORMATION

Is condition due to an accident? ☐ Yes ☐ No

Date _____

Type of accident ☐ Auto ☐ Work ☐ Home ☐ Other

To whom have you made a report of your accident?
☐ Auto Insurance ☐ Employer ☐ Worker Comp. ☐ Other

Attorney Name (if applicable)

_____

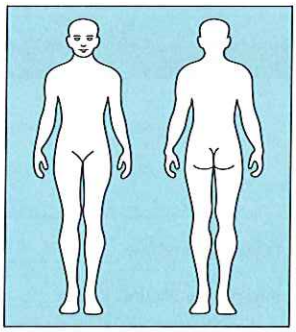
PATIENT CONDITION

Reason for Visit _____

When did your symptoms appear? _____

Is this condition getting progressively worse? ☐ Yes ☐ No ☐ Unknown

Mark an X on the picture where you continue to have pain, numbness, or tingling.



Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

Type of pain: ☐ Sharp ☐ Dull ☐ Throbbing ☐ Numbness ☐ Aching ☐ Shooting
☐ Burning ☐ Tingling ☐ Cramps ☐ Stiffness ☐ Swelling ☐ Other

How often do you have this pain? _____

Is it constant or does it come and go? _____

Does it interfere with your ☐ Work ☐ Sleep ☐ Daily Routine ☐ Recreation

Activities or movements that are painful to perform ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying Down

HEALTH HISTORY

What treatment have you already received for your condition? ☐ Medications ☐ Surgery ☐ Physical Therapy

☐ Chiropractic Services ☐ None ☐ Other _____

Name and address of other doctor(s) who have treated you for your condition _____

Date of Last: Physical Exam_____ Spinal X-Ray_____ Blood Test_____

Spinal Exam_____ Chest X-Ray_____ Urine Test_____

Dental X-Ray_____ MRI, CT-Scan, Bone Scan _____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS/HIV	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Alcoholism	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	Measles	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Allergy Shots	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Migraine Headaches	☐ Yes ☐ No	Sexually Transmitted Disease	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fractures	☐ Yes ☐ No	Miscarriage	☐ Yes ☐ No		
Anorexia	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mononucleosis	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Appendicitis	☐ Yes ☐ No	Goiter	☐ Yes ☐ No	Multiple Sclerosis	☐ Yes ☐ No	Suicide Attempt	☐ Yes ☐ No
Arthritis	☐ Yes ☐ No	Gonorrhea	☐ Yes ☐ No	Mumps	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Gout	☐ Yes ☐ No	Osteoporosis	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Bleeding Disorders	☐ Yes ☐ No	Heart Disease	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Breast Lump	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Parkinson's Disease	☐ Yes ☐ No	Tumors, Growths	☐ Yes ☐ No
Bronchitis	☐ Yes ☐ No	Hernia	☐ Yes ☐ No	Pinched Nerve	☐ Yes ☐ No	Typhoid Fever	☐ Yes ☐ No
Bulimia	☐ Yes ☐ No	Herniated Disk	☐ Yes ☐ No	Pneumonia	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Polio	☐ Yes ☐ No	Vaginal Infections	☐ Yes ☐ No
Cataracts	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Prostate Problem	☐ Yes ☐ No	Whooping Cough	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	High Cholesterol	☐ Yes ☐ No	Prosthesis	☐ Yes ☐ No	Other _____	
Chicken Pox	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No		
				Rheumatoid Arthritis	☐ Yes ☐ No		

EXERCISE

☐ None
☐ Moderate
☐ Daily
☐ Heavy

WORK ACTIVITY

☐ Sitting
☐ Standing
☐ Light Labor
☐ Heavy Labor

HABITS

☐ Smoking Packs/Day _____
☐ Alcohol Drinks/Week _____
☐ Coffee/Caffeine Drinks Cups/Day _____
☐ High Stress Level Reason _____

Are you pregnant? ☐ Yes ☐ No Due Date_____

Injuries/Surgeries you have had	Description	Date
Falls		
Head Injuries		
Broken Bones		
Dislocations		
Surgeries		

MEDICATIONS

_____
_____
_____
Pharmacy Name_____
Pharmacy Phone (____)_____

ALLERGIES

VITAMINS/HERBS/MINERALS