

**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: \_\_\_\_\_

## Long Chiropractic Office Time of Service Discount Policy

Long Chiropractic Office is proud to offer a Time of Service Discount (TOS) to all self paying patients. The TOS discount allows us to provide you with quality care at a reasonable fee.

This discount is approximately 25% off of our regular office fees. This is to only include *services* rendered by our office, and does not include supplements or other purchased supplies or goods.

This discount must be applied at the time of service; therefore full payment is to be collected at the time of service. Accounts will not be balanced billed.

If you are covered under a major medical insurance policy and are choosing to use this discount, no insurance claim will be filed from this office.

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I have read and understand Long Chiropractic Office's Time of Service Discount Policy. I understand that I am financially responsible for any and all balances that occur at the time of service. I also understand that Long Chiropractic Office will not be submitting a claim to my insurance company. By signing this policy I am agreeing to its terms.

Patient Name  
(PRINT) \_\_\_\_\_

Patient/Guardian  
Signature \_\_\_\_\_

Date \_\_\_\_\_

	Long Chiropractic Office Kent C. Long, D.C., D.A.C.R.B. P (937) 278-7246 F (937) 278-5640	
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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    ?**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have a past history of cancer?                            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had any unexplained weight loss?                        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Does your pain improve with rest?                                |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you over 50 years old?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Failure to respond to a course of conservative care (4-6 weeks)? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Have you had spinal pain greater than 4 weeks?                   |

**NO    YES    ?**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Prolonged use of corticosteroids (such as organ transplant Rx)?        |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Intravenous drug use?  |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Current or recent urinary tract, respiratory tract or other infection? |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Immunosuppression medication &/or condition?                           |

**NO    YES    ?**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | History of significant trauma?                   |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Minor trauma in person >50 years old?            |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Do you have osteoporosis (weak bones)?           |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Are you over 70 years old?                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Any history of prolonged use of corticosteroids? |

**NO    YES    ?**

- |                          |                          |                          |  |
|--------------------------|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Acute onset urinary retention or overflow incontinence (wet underwear) |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Loss of anal sphincter tone or fecal incontinence (bowel accidents)    |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Saddle anesthesia (numbness in the groin region)                       |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Global or progressive muscle weakness in the legs (legs give out)      |

**COMMENTS:** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

# 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) \_\_\_\_\_

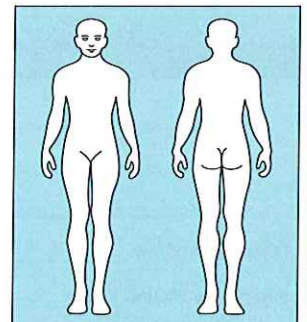
Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting  
 Burning  Tingling  Cramps  Stiffness  Swelling  Other

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

### ALLERGIES

### VITAMINS/HERBS/MINERALS

_____ _____ _____ Pharmacy Name _____ Pharmacy Phone (____) _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____
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