

WELCOME TO:

JAN/2007



ALLIANCE CHIROPRACTIC & WELLNESS / MASSAGE

610 E. Broad Street Souderton, PA 18964 215-723-7500

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PLEASE FILL OUT COMPLETELY

<p>Name _____ Date _____</p> <p>Referred by: _____</p> <p>Address _____</p> <p>_____</p> <p>Phone [H](____) _____ [C](____) _____</p> <p>Workplace _____ [Ph] (____) _____</p> <p>Date of Birth _____ Age _____</p> <p>E-Mail _____</p>	<p style="text-align: center;">SYMPTOMS</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Neck Pain</p> <p><input type="checkbox"/> Arm Pain</p> <p><input type="checkbox"/> Shoulder Pain</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Tingling</p> <p><input type="checkbox"/> Pins & Needles</p> <p><input type="checkbox"/> Weakness</p> <p><input type="checkbox"/> Low Back Pain</p> <p><input type="checkbox"/> Mid Back Pain</p> <p><input type="checkbox"/> Leg Pain</p> <p><input type="checkbox"/> Knee Pain</p> <p><input type="checkbox"/> Hip Pain</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Stress</p> <p><input type="checkbox"/> Pain w/Activity</p> <p><input type="checkbox"/> None</p> <p>Which Pain is the worst?</p> <p>_____</p> <p>How important is it to eliminate this pain? (circle below)</p> <p>Not 0 1 2 3 4 5 Very</p>
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Have you ever received massage therapy? Yes No If yes, where? _____

List problem areas: _____

When did they start? _____

What makes them better? _____ What makes them worse? _____

Does it keep you from the following? Work Exercise Sleep Recreation

Are you currently under a physician's care? _____ Dr. Name: _____ Why? _____

Are you pregnant? Yes No If yes, how far along are you? _____

Are you presently under chiropractic care? Yes No If yes, where? _____

Have you ever been seen by a chiropractor? Yes No If yes, where? _____



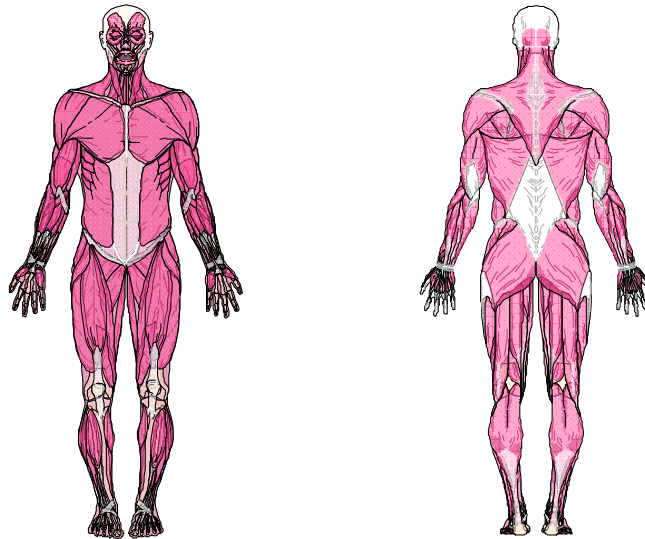
ALLIANCE CHIROPRACTIC & MASSAGE

Dr. Trista DeLuca 610 E. Broad Street Souderton, PA 18964 215-723-7500

*** PLEASE CHECK ANY OF THE FOLLOWING CONDITIONS IF YOU HAVE HAD THEM RECENTLY ***

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Cold hands |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Numbness of hands |
| <input type="checkbox"/> Bursitis | <input type="checkbox"/> Loss of balance | <input type="checkbox"/> Numbness of feet |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Edema |
| <input type="checkbox"/> Varicose Veins | <input type="checkbox"/> Headaches | <input type="checkbox"/> Skin disorders |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> TMJ dysfunction | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Severe Depression | <input type="checkbox"/> Shoulder pain | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Back pain | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Abdominal hernia |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Herniated disc | <input type="checkbox"/> Stomach disorders |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> PMS | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sciatica |

*** PLEASE INDICATE AREAS OF DISCOMFORT, ESPECIALLY TIGHT MUSCLES ***



BECAUSE a massage therapist must be aware of any existing physical conditions that I may have, I have listed all my known medical conditions and physical limitations and I will inform my massage therapist of any changes in my physical health.

I understand and agree that;

1. The massage therapy I am given is for the purpose of stress reduction, relief from muscular tension or spasm and/or for improving circulation.
2. A massage therapist neither diagnoses illness, disease or any other medical, physical or mental disorder, nor performs any spinal manipulations.
3. I am responsible for consulting a qualified physician for any physical ailments that I may have.

I agree that all services rendered me are charged directly to me and I am responsible for payment unless prior arrangements have been made.

I agree to pay for all scheduled appointments unless I notify the office at least 24 hours in advance.

I certify the information given is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE



OFFICE POLICY MESSAGE

- ❖ Arrive 5 minutes early to your scheduled appointment.
- ❖ Cancellations must be made with 24 hours notice.
- ❖ Patients will be charged for full visit if late or no-show.
- ❖ You will receive a discount on your next massage if you schedule your appointment prior to leaving the office.

*Our therapists are on tight schedules and we want to insure
all our patients receive the full service they scheduled.*

Signature _____ Date _____

Thank you for helping us to make this a pleasant experience for all!

ALLIANCE CHIROPRACTIC & MASSAGE

TRISTA M. DELUCA, DC 610 East Broad Street Souderton, PA 18964 215-723-7500

AUTHORIZATION FOR RELEASE OF MESSAGE CLIENT INFORMATION

Print Name _____ Date of Birth _____

I authorize any medical, osteopathic, chiropractic physician, medical practitioner, healthcare provider, rehabilitation facility, hospital, clinic or any other healthcare facility to disclose information from medical and healthcare records.

I understand that the specific type of information to be disclosed includes, but is not limited to, medical and healthcare records and any other information including any history, treatment records, diagnosis, prognosis, narrative reports, diagnostic tests, and billing records. This authorization also permits my medical providers to discuss in person, by telephone, electronically, or by mail, medical options, conclusions, treatment plans, and other information with ALLIANCE CHIROPRACTIC doctors, associates, and staff. I understand Alliance Chiropractic may disclose medical or other information obtained by this authorization to physicians, other medical or healthcare providers or other professions for their professional opinion.

I understand that I may refuse to authorize disclosure of all or some of the requested information. This authorization may be revoked at any time in writing, dated, and signed. This specifically applies to records made before, during, and after the date of signing this authorization for as long as the authorization is in effect.

I have read the authorization and signed this document as a free and voluntary act. I understand this authorization was developed pursuant to the Health Insurance Portability and Accountability Act of 1996. (HIPAA)

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received and read a copy of this office's Privacy Practices and sign this document as a free and voluntary act.

Alliance Chiropractic strives to keep your Health Information Private. We understand your medical information is personal and we are committed to protecting it, however, in our daily procedures, the following may possibly compromise your privacy:

Phone calls; patients' charts and cards in use; x-rays in use; discussions amongst Doctors, Patients, Staff or Authorized visitors; appointment books; mailings; receipt books; computers; bulletin boards.

As a patient in our practice, we may need to communicate with you, please check the forms of communication that are **NOT** acceptable to you.

Cell Phone Home Phone Work Phone Fax Voice Mail Mail E-mail

It is understood that person(s) having access to the same devices may intercept the communication

I understand I have the right to revoke this authorization by writing to Alliance Chiropractic.

I understand I have the right to refuse to sign this authorization.

SIGNATURE OF PATIENT, GUARDIAN OR PERSONAL REPRESENTATIVE

DATE

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because _____