Welcome to the Center of Chiropractic Orthopedics
Dr. Mark J. Sperbeck, D.C., F.A.C.O.
8333 Alexandria Pike, Alexandria, KY 41001
(859) 448-0900

PATIENT INFORMATION

Date_____

Legal name_____

SS #_____

Date of Birth_____ Age_____

Gender: Male Female

Home Phone_____

Cell_____

Work Number_____

Email Address_____

Address_____

City_____

State_____ Zip_____

Employer_____

Occupation_____

Spouse's name_____

Spouse's Employer_____

Referred by_____

Family physician_____

May we contact them regarding your health? Y or N

INSURANCE INFORMATION

Name on account_____

Birthday for account holder_____

Relationship to patient_____

EMERGENCY CONTACT

Name_____

Relationship_____

Home # _____

Work/Cell #_____

Due to HIPPA (privacy) regulations we are giving you the option, to provide in writing, your permission for our office to share your medical and/or billing information with the person(s) you assign.

_____I do not wish to have this option.

_____I authorize the Doctors and/or staff to discuss my medical information with the following names-

Name_____Relationship_____Number_____

Name_____Relationship_____Number_____

Signature of Patient (or Guardian if under 18)_____ Date_____

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PRACTICE'S REQUIREMENTS

The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this privacy notice, detailing the Practice's legal duties and privacy practices with respect to your PHI.
- The practice adheres to Ohio law in those instances where Ohio law does not conflict with the federal law.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of you PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation
- Will not retaliate against you for filing a complaint.

Effective Date:

This notice is in effect as of 04/14/03

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of The Center of Chiropractic Orthopedics' Notice of Privacy Practices.

_____ _____

Signature of patient or patient representative Date

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party agree to pay ALL applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors.

_____ _____

Signature of patient or patient representative Date

TERMS OF ACCEPTANCE

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both to be working for the same objective.

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The state of optimal physical, mental and social well being, not merely the absence of disease or infirmity.

Vertebral subluxation: A misalignment of one or more of the 24 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnose either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter non-chiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

Regardless of what the disease is called, we do not offer to treat it, nor do we offer advice regarding treatment prescribed by others. OUR PRACTICE OBJECTIVE is to eliminate major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxations. However, we may use other procedures to help your body hold the adjustments.

I (please print)_____ read fully and understand the above statement

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

_____ _____

Signature of patient Date

Consent to evaluate and adjust a minor child

I_____ being the parent or legal guardian of_____

Have read and fully understood the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

This is to certify that to the best of my knowledge I am not pregnant and the Doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child. Date of last menstrual cycle_____

Please Sign:_____ Date:_____

PATIENT CONDITION

Fill in all information to the best of your knowledge

Reason for visit_____

_____

_____

When did your symptoms start?_____

How did your problem start?_____

Rate your level of pain **today**: (circle one--0 no pain, 10 severe pain) 0 1 2 3 4 5 6 7 8 9 10

Is your pain: ☐ Constant (100% of day) ☐ Frequent (75%) ☐ Occasional (50%) ☐ Intermittent (25%)

Describe the pain: ☐ Sharp ☐ Dull ache ☐ Shooting ☐ Burning ☐ Throbbing
☐ Stabbing ☐ Numbness ☐ Tingling

Is your condition: ☐ Getting Better ☐ Staying the same ☐ Getting worse

Does it interfere with: ☐ Work ☐ Sleep ☐ Recreation ☐ Daily activity ☐ Nothing

What makes you worse: ☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lying down

What makes you better: ☐ Nothing ☐ Rest ☐ Activity ☐ Heat ☐ Cold ☐ Medication

What tests have you had: ☐ X-rays ☐ MRI ☐ EMG ☐ Ultrasound ☐ Lab work

What treatment have you had: ☐ Drugs ☐ Nerve blocks ☐ PT ☐ Surgery

Has the treatment helped: ☐ Yes ☐ No Have you ever had this problem before: ☐ Yes ☐ No

SOCIAL HISTORY

Marital status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed

Use of alcohol: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Use of tobacco: ☐ Never ☐ Rarely ☐ Moderate ☐ Daily

Work activity: ☐ Sitting ☐ Standing ☐ Light labor ☐ Heavy labor

Exercise Activity: ☐ None ☐ Light ☐ Moderate ☐ Strenuous

FAMILY HISTORY

(Please circle yes or no for the following)

	Living		Rheumatoid Arth.		Cancer		Diabetes		Heart problems		Back problems	
Father:	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Mother:	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Sibling(s):	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

(Check all that apply to you)

Constitutional: ☐ Bad general health ☐ Recent weight change ☐ Fever ☐ Fatigue ☐ Headaches

Ear, Nose, Throat: ☐ Hard of hearing ☐ Ringing in the ears ☐ Vertigo ☐ Sinus problems
☐ Nose bleeds ☐ Sore throat/ Voice change ☐ Swollen glands

Eyes: ☐ Eye disease/injury ☐ Glasses or contact lens ☐ Blurred/ double vision

Neurological: ☐ Seizures or Epilepsy ☐ Numbness/ Tingling ☐ Tremors ☐ Stroke

Musculoskeletal: ☐ Joint pain/ Stiffness ☐ Joint swelling ☐ Arthritis ☐ Osteoporosis
☐ Fibromyalgia ☐ Chronic fatigue

Cardiovascular: ☐ Chest pain/ Palpitations ☐ Dizziness/ Fainting ☐ Shortness of breath ☐ Heart attack
☐ Swelling in hands/ Feet ☐ High blood pressure ☐ High cholesterol ☐ Congestive heart failure

Gastrointestinal: ☐ Heartburn ☐ Nausea/ Vomiting ☐ Diarrhea/ Constipation ☐ Blood in stools
☐ Gall bladder problems ☐ Liver problems ☐ Ulcers

Genito-urinary: ☐ Pain/Difficulty urination ☐ Blood in urine ☐ Incontinence ☐ Kidney stones/problems

Respiratory: ☐ Cough ☐ Congestion ☐ Wheezing ☐ Asthma ☐ Emphysema ☐ Pneumonia

Psychiatric: ☐ Anxiety/ Depression ☐ Mood swings ☐ Difficulty sleeping ☐ Memory loss

Hematologic/ Lymphatic: ☐ Slow to heal after cuts ☐ Bleed or bruise easily ☐ Anemia ☐ Enlarged glands

Endocrine: ☐ Excessive thirst/ Urination ☐ Heat or cold intolerance ☐ Skin becoming drier
☐ Diabetes ☐ Thyroid disorder

Integumetary: ☐ Rash/ Sores ☐ Lesions ☐ Breast pain or lump ☐ Dermatitis/ Eczema

Allergic/ Immunologic: ☐ Food allergies ☐ Airborne allergies ☐ Systemic Lupus ☐ Cancer ☐ HIV/ AIDS

LIST OF HOPITALIZATIONS & SURGERIES

Falls_____

Fractures_____

Hospitalizations_____

Surgeries_____

MEDICATIONS & ALLERGIES

Medications:_____

Supplements:_____

Allergies:_____

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic any changes in my medical status.

_____ _____

Signature of patient or patient representative Date