Southern Tier Chiropractic PLLC
@: Complementary Medicine & Healing Arts
27 Jenison Avenue
Johnson City, NY 13790
607-729-0591 (Tel)

Daniel G. Miller, D.C.

607-729-0967 (Fax)

Patient Information:

Name: _____ S.S.#: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Employer: _____

Date of Birth: _____ Age: _____ Gender: Male/Female

Marital Status: SingleMarried Divorced Widowed Other

Spouse's Name: _____ Phone: _____

Spouse's Employer: _____ Phone: _____

Emergency Contact (Not living with you): _____ Phone: _____

Primary MD: _____ Clinic: _____ Phone: _____

Please fill out the insurance information below regardless of status:

Is the reason you are seeing the doctor today due to a work related injury? Yes / No

If yes, when did the accident occur? _____

Did you file a formal incident report with your employer within 24 hours of the injury? Yes / No

Is the reason you are seeing the doctor today due to a personal injury or no-fault auto accident? Yes / No

If yes, when did the injury or accident take place? _____

Was there a Police report filed? Yes / No

Have you contacted your insurance agency regarding the accident? Yes / No

Type of insurance:

Auto Personal Injury Worker Compensation Medicare Other No Coverage

Insurance Company Name:_____ Phone: _____

Address: _____ City: _____ State:_____ Zip: _____

ID#/Claim#: _____ Group#: _____ Contact: _____

Insured Name: _____ Birth Date: _____ SS#: _____

Attorney: _____ Phone:_____

Address:_____ City: _____ State:_____ Zip: _____

By signing below, you authorize Dr. Daniel G. Miller, D.C., DACNB to release all information necessary to secure payment of charges. You also agree to the assignment of insurance benefits to be assigned to Dr. Daniel G Miller, D.C., DACNB of Southern Tier Chiropractic PLLC. By signing below you understand that Southern Tier Chiropractic acts as the billing agent for all services rendered by the above named doctor regarding the billing and collection of payment for services rendered. Further note that by signing below you understand that all applicable co-payments and extra charges related to services provided are due at the time of services unless otherwise agreed to prior to services being rendered.

There will be a $25.00 service charge applied to all returned checks.

Independent Medical Examinations are set up and paid for by either the insurance company covering your claim and/or the governing body that is managing your case. You are not directly responsible for the services rendered here today.

Patient Signature: _____ Date: _____

If under 18 you need a parent or legal guardian with you for each appointment.

Parent or Guardian Signature:_____ Date: _____

Patient Questionnaire

In your own words describe your current symptom(s):

_____

_____

_____

On a scale of 0 (no pain) and 10 (worse pain you have ever experienced), how do you rate your condition currently? _____

Have you noticed anything that makes your current symptoms better?

_____

Have you noticed anything that makes your current symptoms worse?

_____

Since the onset of your symptoms have you noticed any improvement? Yes / No

If yes, how much? 0-25%, 25-50%, 50-75%, 75-100%

Please indicate the % of the day that your symptoms are present:

0-25%, 25-50%, 50-75%, 75-100%

Does your symptoms cause you to wake up from a sound sleep? Yes / No

Since the onset of your symptoms have you noticed any unexplained increase or decrease in weight? Yes / No

Since the onset of symptoms have you noticed any abnormal discharge of blood? Yes / No

Indicate which of the following activities makes your symptoms better or worse

Better/Worse **Sitting** Better/Worse **Bending Forward** Better/Worse **Movement/Activity**

Better/Worse **Lying Down** Better/Worse **Other:** _____

How did the symptom(s) start? 1. Gradual onset 2. Work injury 3. Motor vehicle accident

4. Other injury: _____

When did your symptom(s) start? (day – month – year) _____

List all medications that you are taking. Please include all supplements.

Medication/Supplement	Type*	Amount Taken	Condition Taken For

* Rx for Prescription, OTC for Over The Counter, Sup for Supplement

List all surgical procedures you have had.

Surgical Procedure	Date Performed	Condition Performed For

Are you currently, or do you anticipate being, involved in any litigation relating to your symptom(s)? Yes / No

Are you currently receiving, or applying for, any disability benefits? Yes / No

If yes what? Worker's Compensation Auto Insurance Social Security
Long Term Disability Other None

What hand do you use to write with? Right, Left, Both

Height: _____ Weight: _____

What is the highest level of education you have completed?

_____

Patient Signature/Date: _____

Guardian Signature/Date: _____

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Patient Name: _____ S.S.#: _____ Date: _____

Please Mark any conditions or symptoms that you have had in the **past** or are **currently** experiencing:

	General History		**Neurological System**		**Cardiovascular System**
	Trauma/Injuries		Headaches		Shortness Of Breath
	Height Change		Epileptic Seizures		Times A Day:
	Fever/Chills		Tics/Spasms		How Often:
	Sweats		Dizziness/Fainting		Chest Discomfort/Pain
	Allergies		Disturbance In Sensation		Type:
	Anemia		Stroke		How Often:
	Bleeding/Bruising		Other:		Palpitations
	Malaise/Fatigue/Weakness		**Gastrointestinal System**		Edema/Swelling
	Family History		Change In Appetite		Fainting
	Diabetes		Food Intolerance		Sudden Calf Pain While Walking
	Thyroid Disease		Nausea/Vomiting Of Blood		How Often:
	Tuberculosis		Peptic Ulcer		High Blood Pressure
	Kidney Disease		Indigestion/Heartburn		Past Heart Disease
	High Blood Pressure		Abdominal Pain		Rheumatic Fever
	Heart Disease/Stroke		Abdominal Swelling		Other:
	Musculoskeletal Disease		Gas		**Respiratory System**
	Cancer		Change In Stool/Color, Etc		Difficulty In Breathing
	Other:		Diarrhea		Cough
	Endocrine System		Hernia		Blood In Sputum
	Thyroid Problems		Hemorrhoids		Wheezing/Asthma
	Diabetes		Gallbladder Disease		Tuberculosis/Exposure
	Neck Surgery/Irradiation		Liver Disease		Pneumonia/Lung Infections
	Other:		Pancreatitis		Unusual Weakness
	Eye/Ear/Nose/Throat		Alcohol Intake		Head Trauma
	Visual Problems		Type:		Cigarette Smoking History:
	Eye Irritation		Amount:		Daily #: # Years:
	Pain In Eyes		**Urinary System**		Other Tobacco Use:
	Other Eye Problems		Frequent Urination		Cigar: Pipe:
	Difficulty Hearing/Deaf		#Day : /#Night:		Chewing Tobacco
	Ringing In Ears/Dizziness		Daily Fluid Intake:		Daily Amount: # Years:
	Ear Growths/Discharge		Pain On Urination		Environmental Toxic Exposure
	Nosebleeds		Change In Urine/Color, Etc.		Type Of Exp:
	Change In Ability To Smell		Difficulty In Starting Stream		Amount:
	Sneezing		Difficulty In Holding Urine		Other:
	Nose Growths/Discharge		Discharge		**Implants**
	Nose Pain		Urinary Tract Infections		Breast Implants

	Sinusitis		Kidney Disease		Cardiac Pacemaker, Etc.
	Other Nose Problems		Flank Pain		Penile
	Hoarseness		Pelvic Pain		Other:
	Change In Voice		Other:		**Female Patients Only: Menstruation/Obstetrics**
	Difficulty Swallowing		**Musculoskeletal System**		
	Enlarged/Painful Glands		Joint Stiffness/Decreased Motion		Menarch (1st Period)
	Change In Ability To Taste		Joint Pain		Age: Year:
	Growths/Lesions In Mouth/Throat		Joint Swelling		Menstrual Flow: Scant Light
	Dental Problems		Muscle Cramps		Moderate Heavy
	Other:		Muscle Weakness		Menstrual Regularity/Days In Cycle:
	Breast		Muscle Wasting		Duration # of days:
	Bumps/Lumps/Mass		Neck Pain		Menstrual Cramping:
	Dimples In Breast		Mid Back Pain		Pain: 0 1 2 3 4 5
	Changes In Color/Size/Shape		Low Back Pain		First Day Of Last Cycle:
	Nipple Discharge		Sacroiliac Pain		Date of Last PAP Test:
	Other:		Tailbone Pain		Menopause: Onset
	Reproductive System		Arm Problems		Post Menopausal Bleeding
	Genital Lesions/Sores		Leg Problems		Abdominal/Painful Premenstrual Fluid Retention?
	Genital Mass/Growths/Pain		Fractures/Dislocation Sprain/Strain		Other Female Problems:
	Syphilis		Other Injuries:		# Of Pregnancies:
	HIV Positive		Other:		# Of Children:
	Gonorrhea		**Psychological History**		Difficult Delivery
	Change In Sex Drive		Anxiety		PMS (Premenstrual Syndrome)
	Birth Control Method		Depression		Hysterectomy: Date:
	Type:		Hospitalization/Therapy		
	How Long:		Other:		
	Other Sexual Difficulties		**Hospitalizations and Medications**		
	Skin/Hair/Nails		Other Hospitalizations Not Listed		
	Change In Skin Texture		Current Use of Any Drugs:		
	Change In Skin Temp		Prescription, OTC, Recreational		
	Skin Dryness/Wetness		Diet – Vitamins		
	Unusual Skin Coloration		Do You Eat Meals Sporadically?		
	Rashes/Itching/Sores		Do You Have An Unusual Appetite?		
	Skin Growths		Large Small		
	Mole Changes		Do You Skip Breakfast?		
	Skin Cancer		Do You Eat Between Meals?		
	Skin Pain		Do You Eat A Late Night Snack Before Bed?		
	Change In Hair/Texture/Condition		Do You Eat Junk Food?		
	Change In Hair Growth/Loss		Are You On A Special Diet?		
	Change In Shape Of Finger Or Toenail		Are You A Vegetarian?		
	Change In Color Of Nails		Type: # Years:		
	Other:		Are You Taking Any Supplements?		

Patient Signature/Date: _____

Guardian Signature/Date: _____

Patient Name _____ Date ____ /____ /____

How long have you had your symptoms? ____ days ____weeks ____ months ____ years

On the diagram below, please indicate where, and what type of symptoms that you are experiencing, right now. Write the appropriate abbreviations (see the key below) over the area of the body where those symptoms are occurring.

A = ACHE

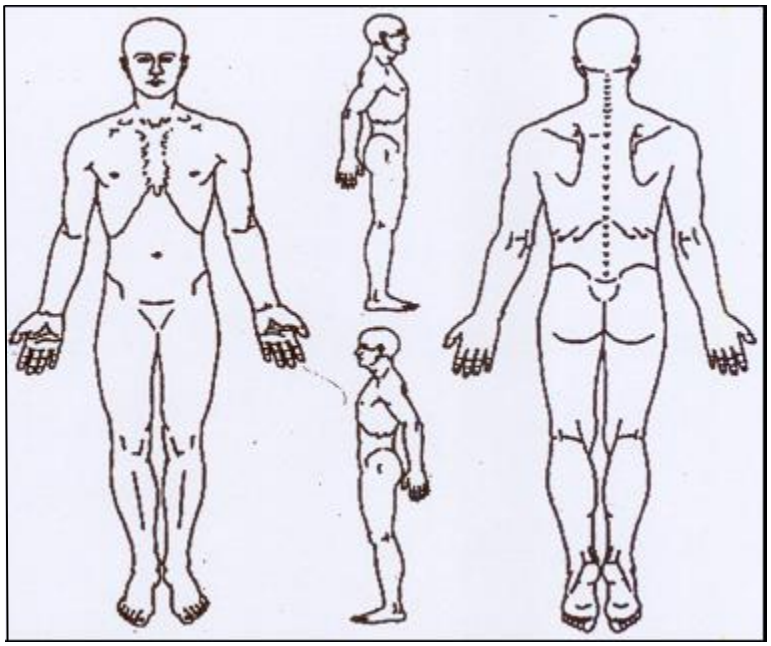
B = BURNING

N = NUMBNESS

P = PINS & NEEDLES

S = STABBING

O = OTHER _____



Instructions: Please fill in the bubble that corresponds to the pain level that you are experiencing.

Note: If you have more than one complaint, please indicate your pain levels for each complaint. Please indicate your pain level for 1. Your pain at its worst, 2. Your pain at its least and 3. Your average pain level.

Example:

No Pain (1) (2) (3) (4) ● (6) (7) (8) (9) (10) Worst Possible

1. My pain when it is at its worst is:

No Pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Worst Possible

2. My pain when it is at its least is:

No Pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Worst Possible

3. My average pain level is:

No Pain (1) (2) (3) (4) (5) (6) (7) (8) (9) (10) Worst Possible

Patient/Other Signature: _____ Relationship to Patient: _____

Provider Signature: _____ Date: _____

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INFORMED CONSENT

I have received information about my condition and proposed treatment program as well as alternative courses of care, the benefits, the risks, and the side effects of the treatment and the consequences of not having the proposed treatment.

I understand, and am informed that, as in all health care, in the practice of chiropractic there are some rare risks to treatment, including but not limited to, muscle strains and sprains, fractures, dislocations, disc injuries, and strokes. I do not expect the doctor to be able to anticipate or explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the treatments, which they feel at the time, based upon the facts, then known, is in my best interests.

My doctor has responded to my entire request for information about the proposed treatment. I have read, or have had read to me, the above consent. I have also had the opportunity to ask questions about its content.

By signing below, I consent to chiropractic treatment.

_____	_____	_____
Print Patient's Name	Signature of Patient	Date
_____	_____	_____
Print Parent/Guardian's Name	Signature of Parent/Guardian	Date
_____	_____	_____
Print Witness Name	Signature of Witness	Date
_____	_____	
Clinician's Initials	Date	

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Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning those records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPPA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this chiropractic office to use their Patient Health Information (PHI) for the purpose of treatment, payment healthcare operations, and coordination of care. As an example, the patient agrees to allow this chiropractic office to submit requested PHI to the health insurance company (companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health record at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to those restrictions.
3. A patient's written consent need only be obtained one time for all subsequent care given the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of those records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known in this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. Patient authorizes Southern Tier Chiropractic PLLC to contact them regarding their care or administrative activities associated with their care at the addresses they provided at the time of intake. The patient has the right to alter or specifically specify the address and/or telephone number they wish to be contacted. The patient may alter or amend their contact information at any time in writing.
8. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the chiropractic physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I agree to these policies and procedures.

Signature of Patient: _____ Date: _____
Signature of Parent/Guardian: _____ Date: _____