



DR. LAURA E. HARRINGTON
 Liverpool Chiropractic & Wellness, PLLC

403 Tulip Street
 Liverpool, New York 13088
 Telephone: (315) 461-4510

Questionnaire (Confidential)

Date: _____

Client Name: _____ Called Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Pager Number: _____

Email Address: _____ Sex: M F

Check Box: Minor Single Married Domestic Partner Separated Divorced Widowed

Birthdate: _____ Age: _____ Social Security #: _____

Are you here because of a: **Work related injury?** Yes No **Auto accident?** Yes No

How did you hear about our office? Referral, by whom? _____
 Office Sign Yellow Pages Newspaper
 Other (please specify) _____

Primary M.D.: _____ Phone: _____

May we contact you Primary M.D. regarding your care in this office? Yes No

Occupation: _____
 (Describe activities involved – sitting, standing, lifting)

Employer Name: _____

Address: _____

City: _____ State: _____ Zip: _____

May we contact you at work, if necessary? Yes No

Person to contact in case of emergency: _____ Phone #: _____

I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administering claims for insurance, Medicare, Worker's Compensation, and No-Fault (auto accidents). I also authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of this signature on all my insurance submissions.

I certify that I have read and understand the following information. To the best of my knowledge the following questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health.

X _____
 Signature of client (or parent if minor)

 Date



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TERMS OF ACCEPTANCE

When a client seeks chiropractic health care and we accept a client 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 client understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

- **Adjustment:** The adjustment is 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 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 diagnosis either vertebral subluxations or neuro-musculoskeletal conditions. However, during the course of a chiropractic spinal examination, if we encounter non-chiropractic or unusual findings, 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 ONLY 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, _____ have read and fully understand the above statements.
 (Print Name)

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)

 (Date)

Consent to evaluate and adjust a minor child

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.

Pregnancy Release

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

 (Signature)

 (Date)



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Financial Policies

Purpose: To provide a clear explanation of our financial policies in advance so that we may better serve you and to prevent any upsets over financial concerns.

CASH

1. All clients are on a cash basis until their respective insurance coverage and deductible is verified by our staff.
2. This office may make payment plans on an individual basis. Any such plan or arrangement will be discussed after the Spinal Health Workshop.

INSURANCE

If you have insurance, we will gladly take assignment in most cases with the following exceptions and regulations, provided we have prior authorization from your insurance company. There are additional guidelines that apply to patients of Medicare or other federally reimbursed programs.

1. We accept assignment as a courtesy to you; you are responsible for your entire bill should your insurance company not pay any anticipated charges for any reason. We are not a mediator between you and your insurance company and will not enter into any dispute with same, as your contract is between you and your insurance company. _____ *Initial*
2. Any services not covered or coverage reductions by your insurance company will be the patient's responsibility. ***This includes sEMG's, which we collect \$25.00 at the time they are rendered.*** _____ *Initial*
3. Every insurance company is different and payments as well as denials are subject to your individual policy. **While we have taken efforts to verify your insurance, this is not a guarantee of benefits.** Any managed care plans administered by ACN may not be covered. Services performed do not constitute a guarantee of payment by your insurance company. _____ *Initial*
4. Changes in your insurance are to be reported to this office as soon as possible to prevent delays in billing. If this information is not received by our office and your claim is denied, you will be responsible for the entire bill.
5. Payments made by your insurance company directly to you for services rendered in this office should be returned to this office upon receipt. If any over-payment exists after all insurance billing has been done, we will issue an over-payment check.
6. This office will resubmit a claim ONE TIME. We will not enter into any dispute with your insurance company. If coverage problems arise, you will be expected to assist directly in dealing with your insurance company, adjustor or agent. Any denied or disputed claims will be treated as uncovered services and you will be expected to pay such charges in a timely fashion.
7. If you have any questions concerning this or any other matter, please speak with the staff prior to seeing the Doctor.

I agree to keep my account balance up to date and understand that I will be charged a service fee if my account is sent to collections. _____ *Initial*

I have read and understand the Financial Policies above and agree to abide by these terms.

Client Signature

Date

Health Questionnaire

Client Name: _____

Date: _____

For each of the conditions listed below, place a check in the Past Column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Back feels out of place	<input type="checkbox"/>	<input type="checkbox"/>	Chronic sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary difficulty
<input type="checkbox"/>	<input type="checkbox"/>	Back Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	Digestive problems	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins
<input type="checkbox"/>	<input type="checkbox"/>	Back weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Vascular problems
<input type="checkbox"/>	<input type="checkbox"/>	Grinding/popping sounds	<input type="checkbox"/>	<input type="checkbox"/>	Poor circulation	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting/Vomiting blood
<input type="checkbox"/>	<input type="checkbox"/>	Herniated disc	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	Weight change
<input type="checkbox"/>	<input type="checkbox"/>	Leg cramps	<input type="checkbox"/>	<input type="checkbox"/>	Asthma			Smoking history
<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasms	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorders			How much/long? _____
<input type="checkbox"/>	<input type="checkbox"/>	Numbness	<input type="checkbox"/>	<input type="checkbox"/>	Dental problems			Men only
<input type="checkbox"/>	<input type="checkbox"/>	Pain from front to back	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Erectile difficulties
<input type="checkbox"/>	<input type="checkbox"/>	Pinched nerve	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue			Women only
<input type="checkbox"/>	<input type="checkbox"/>	Pins & needles	<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Extreme menstrual pain
<input type="checkbox"/>	<input type="checkbox"/>	Tension in back	<input type="checkbox"/>	<input type="checkbox"/>	Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes
<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss or Ringing	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriage
<input type="checkbox"/>	<input type="checkbox"/>	Pain between shoulder blades	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Painful intercourse
<input type="checkbox"/>	<input type="checkbox"/>	Pain in shoulder joint	<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Pain across shoulders	<input type="checkbox"/>	<input type="checkbox"/>	Mononucleosis			Method of birth control _____
<input type="checkbox"/>	<input type="checkbox"/>	Can't raise arm	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis			Are you nursing? Y/ N _____
		<input type="checkbox"/> Above shoulder level	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis			Number of children _____
		<input type="checkbox"/> Over head	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker			Have you ever taken birth control pills? _____
<input type="checkbox"/>	<input type="checkbox"/>	Migraines/Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough			When? _____
<input type="checkbox"/>	<input type="checkbox"/>	Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Polio			
<input type="checkbox"/>	<input type="checkbox"/>	Bloating/Gas	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric care			
<input type="checkbox"/>	<input type="checkbox"/>	Constipation/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Sweats			

Please indicate if YOU or any of your immediate family has or had any of the following:

- Cancer Thyroid Problems Rheumatoid Arthritis Heart Problems/Stroke Diabetes Lupus

List any prescription/over-the-counter medications and vitamins you are currently taking: _____

List any allergies: _____

List all surgical procedures and hospitalizations: _____

When did you last see a chiropractor? _____ Dr: _____

Why did you see this chiropractor? _____ Were you helped? _____

What spinal maintenance programs were you given to follow to maximize the future stability of you spine? _____

Did you follow it? _____ If not, why? _____

Why are you changing chiropractors? _____

Why did you come into our clinic and what are your expectations of us? _____

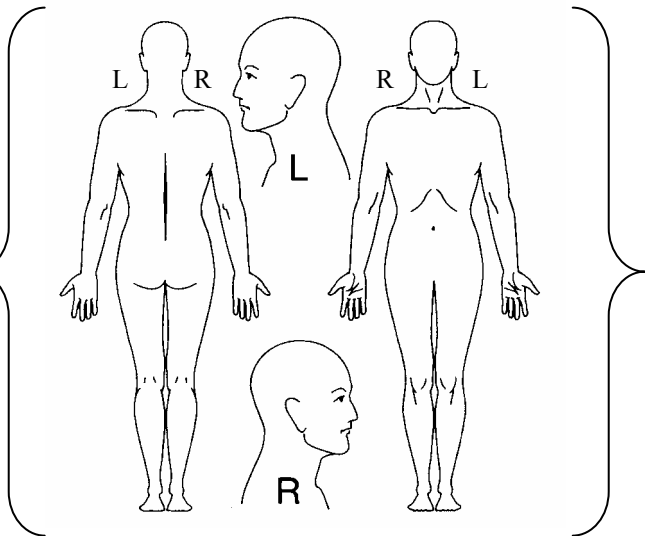
What is your health philosophy? (What should you do to be healthy?) _____

Client Name: _____

Date: _____

Please use the following descriptive symbols on the body to the right to describe the location of your problem.

Aching ^^^	Burning ====	Pins & Needles -----
Numberness 000000	Stabbing ////////	Other XXXXXX
		XXXXXX



What type of regular exercise do you perform?

- None Light Moderate Strenuous

What is your height and weight?

Height _____ Weight _____ Shoe Size _____

When/How did your symptoms start? _____

What are your symptoms? _____

Have you had similar symptoms in the past? _____

How often do you experience these symptoms?

- Constantly (76%-100%) Frequently (51%-75%) Occasionally (26-50%) Intermittently (<25%)

How would you describe your symptoms?

- Sharp Dull Numb Shooting Burning Tingling

Please circle the level of pain on this scale at its worst: None 1 2 3 4 5 6 7 8 9 10 Worst Possible

Please circle the level of pain on this scale at its best: None 1 2 3 4 5 6 7 8 9 10 Worst Possible

How are your symptoms changing? Getting Worse Not Changing Getting Better

On a scale of 1-10 (10 being the most, and 1 being the least),

_____ **How committed are you at being at your maximum health potential?**

_____ **How important is it for your family to be at their optimal health potential?**

_____ **How committed are you to preventing arthritis and maximizing your spinal stability?**

Most clients that come to our office have one of two objectives in mind concerning their health care. Some clients come for symptomatic relief of pain or discomfort (**Relief Care**). Others are interested in having the cause of the problem as well as the symptoms corrected and relieved (**Corrective Care**). Your Doctor will weigh your needs and desires when recommending your treatment program.

Please check the type of care desired so that we may be guided by your wishes whenever possible:

- Relief Care** (Help the symptom but do not fix the cause of the problem)
- Corrective Care** (Correct the cause of the problem for maximum stability in the future)
- Check here if you want the Doctor to select the type of care appropriate for your condition

X _____
Signature of client (or parent if minor)

Date



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Client Name: _____

Date: _____

If you are using Medical Insurance to help pay for care, please fill out the insurance questionnaire below.

Insurance Questionnaire (Confidential)

Primary Insurance Company Name: _____

Subscriber ID Number: _____ Group Number: _____

Primary Insured Name: _____

Address (If different): _____

City: _____ State: _____ Zip: _____

Primary Insured's Employer Name: _____

Primary Insured Birthdate: _____ Sex: M F

Relation: Self Spouse Child Other / Domestic Partner

If you have secondary insurance, please complete the following:

Secondary Insurance Company Name: _____

Subscriber ID Number: _____ Group Number: _____

Secondary Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Secondary Insured's Employer Name: _____

Secondary Insured Birthdate: _____ Sex: M F

Relation: Self Spouse Child Other / Domestic Partner

If you have tertiary (3rd) insurance, please complete the following:

Tertiary Insurance Company Name: _____

Subscriber ID Number: _____ Group Number: _____

Tertiary Insured Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Tertiary Insured's Employer Name: _____

Tertiary Insured Birthdate: _____ Sex: M F

Relation: Self Spouse Child Other / Domestic Partner