Fuller Chiropractic and Sports Injury Center

Dr. David Fuller, Dr. Brian Berg
909 Sumneytown Pike, Suite 107
Spring House, PA 19477

www.ChiroAndSports.com
Phone: (267) 419-8748
Fax: (267) 705-2087

Name: _____ D.O.B: ____/____/_____ Sex: ❑ M / ❑ F

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

Best Phone #: (____)_____-_____ (home - cell - work) Alternate #: (____)_____-_____ (home - cell - work)

Email: _____ Marital Status: M - S - W - D # of children?: _____

Emergency Contact: _____ Phone #: (____)_____-_____ Relationship: _____

Occupation: _____ Employer: _____ Work #: (____)_____-_____

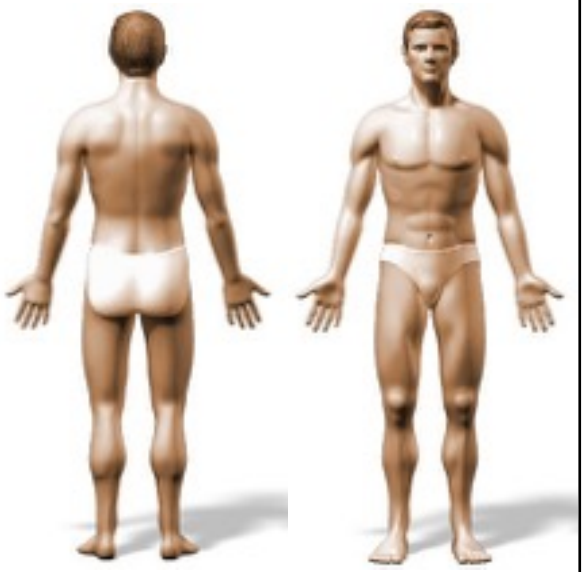
Family Physician: _____ Phone #: (____)_____-_____

Who should we thank for referring you to our office? _____

Purpose for this appointment: _____

Is this work related? ❑ Yes / ❑ No Auto accident? ❑ Yes / ❑ No If yes, date of accident: ____/____/_____

Please mark on the diagram below where you are feeling discomfort:



Please rate your CURRENT level of discomfort on the following scale: *(circle one)*

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
(no pain) *(worst pain)*

How would you rate your discomfort when at its WORST:

0 - 1 - 2 - 3 - 4 - 5 - 6 - 7 - 8 - 9 - 10
(no pain) *(worst pain)*

What percentage of the time do you feel this discomfort?

10% - 20% - 30% - 40% - 50% - 60% - 70% - 80% - 90% - 100%

When did your symptoms begin? _____

Is it getting worse? ❑ Yes / ❑ No

What makes your condition feel better (if anything)?

_____

What aggravates your condition?

_____

Is your condition interfering with any of the following? *(check all that apply)*

❑ Work ❑ Sleep ❑ Mood ❑ Daily Routine ❑ Recreation

What is the quality of the discomfort? *(Please circle all that apply)*

Aching Burning Cramping Deep Dull Intense Numb Pain Random Location/Time
Severe Sharp Shooting Stiffness Superficial Throbbing Tingling Tightness

When is the discomfort at its worst? *(Please circle)*

Upon waking - Morning - Afternoon - Evening - Middle of night - No pattern

What treatments have you tried for this condition (if any)? _____

_____

List ALL medications you are currently taking: _____

_____

Hospitalizations/Surgeries: _____

Fractures or broken bones: _____

Are you on blood thinners? ❑ Yes / ❑ No Are you pregnant? ❑ Yes / ❑ No Taking birth control? ❑ Yes / ❑ No

Do you smoke? Currently - Past - Never If yes, how much? _____ For how long?_____

Exercise? ❑ Yes / ❑ No How often? _____ Use Alcohol? ❑ Yes / ❑ No # of drinks per week? _____

Which supplements/vitamins do you take? _____

Have you had or do you have any of the following conditions? *(Please circle all that apply)*

HIV/AIDS Anemia Anorexia Appendicitis Arthritis Asthma Bleeding Disorder
Autoimmune Problems Bronchitis Cancer Depression Diabetes Miscarriage
Emphysema Epilepsy Heart Disease Hernia Herniated Disc High Cholesterol
Kidney Disease Liver Disease Migraines MS Osteoporosis Pacemaker Tumor
Parkinson's Pinched Nerve Pneumonia Polio Prostate Problems Strokes
Rheumatoid Arthritis Thyroid Problems Ulcers Hepatitis Artificial Joints
NONE APPLY

Family History: *Place an "X" in any box that may apply*

	Self	Spouse	Child		Self	Spouse	Child
Back Pain				Scoliosis			
Neck Pain				Tendonitis			
Headaches				Asthma			
Arthritis				Carpal Tunnel			
Pinched Nerves				Ear Infections			

I understand the above information and guarantee this form was completed correctly to the best of my knowledge, and understand it is my responsibility to inform this office of any changes to the information I have provided.

Patient's Signature: _____ Today's Date: _____

Guardian's Signature: _____ Today's Date: _____

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Authorization and Release:

I authorize the doctor to release all information necessary to communicate with personal physicians, healthcare providers, and my insurance company. I also understand that if I suspend or terminate my schedule of care as determined by my treating doctor, any fees for professional services will immediately be due and payable. I understand that interest is charged on overdue (45 days past due) accounts at the annual rate of 16%. If applicable, I authorize payment of insurance benefits directly to the chiropractor or chiropractic office. I understand that if my insurance company does not pay for services rendered, I will be responsible for payment.

The patient understands and agrees to allow this chiropractic office to use their Patient Health Information for the purpose of treatment, payment, heath care operations, coordination of care. We want you to know how your Patient Health Information is going to be used in this office and your rights concerning those records. 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. If there is anyone you do not want to receive your medical records, please inform our office.

Patient's Signature: _____ Date: _____

Guardian's Signature: _____ Date: _____

____ Initials **I understand that no call/no shows or cancelling an appointment within 6 hours of my appointment time will result in a charge.**

____ Initials **Repeated missed appointments may result in a discharge from the practice.**

Medicare:

I understand that Active Release is not a covered service by Medicare. I accept that this office is not a participating provider with Medicare; therefore, I am responsible for payment of all services provided by this office. I also understand that I cannot submit any bills from this office to Medicare or any of Medicare's secondary insurances.

Patient's Signature: _____ Date: _____

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TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. It is important that each patient understand both the objective and the method that will be used to attain it.

Adjustment: An adjustment is the specific application of forces to facilitate the body's correction of a vertebral subluxation. Our chiropractic method provides specific adjustments to the spine.

Health: A 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 vertebrae in the spinal column causing an alteration of nerve function. This interferes with the transmission of mental impulses and results in a lessening of the body's innate ability to express its maximum health potential.

Active Release Technique: The process of taking a soft tissue structure through its entire range of motion while tensioning on adhesions or scar tissue.

We do not offer to diagnose or treat any disease or conditions other than a vertebral subluxation. However, if during the course of a chiropractic spinal examination, we encounter non-chiropractic unusual findings, we will advise you. If you desire advice, diagnosis, or treatment of those findings we will recommend that you seek the services of the health care provider who specializes in that area.

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 a major interference to the expression of the body's innate wisdom. Our method is specific adjusting to correct vertebral subluxations.

I, _____, have read and fully understand the above statements.

I, therefore, accept chiropractic care on this basis.

Signature: _____ Date: _____