Acct No: ________

INITIAL HEALTH STATUS (Chiropractic)

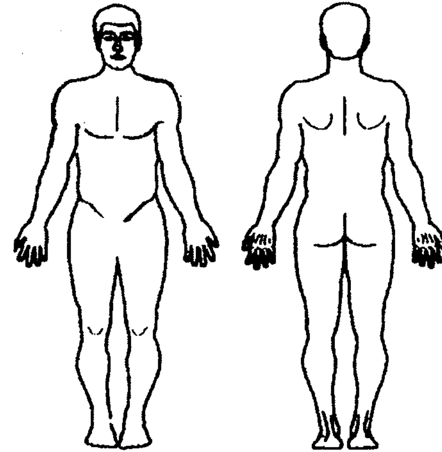
Patient: ____________________ Birthdate: ________ Sex: M / F

Address: ____________________ City, State, Zip: ____________________

Phone: ( ) - ________

PCP: ____________________ PCP Phone: ( ) - ________

MARK AN **X** ON THE PICTURE WHERE YOU HAVE PAIN OR OTHER SYMPTOMS



DESCRIBE YOUR CURRENT PROBLEM AND HOW IT BEGAN:

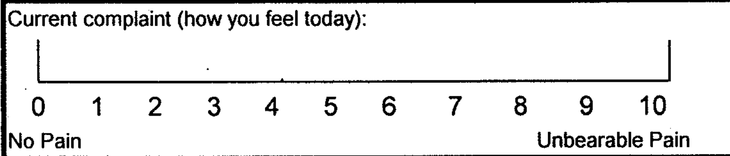
☐ Headache ☐ Neck Pain ☐ Mid-Back Pain ☐ Low Back Pain

☐ Other: ____________________

Is this? ☐ Work Related ☐ Auto Related ☐ N/A

Date Problem Began: ____________________

How Problem Began: ____________________



Current complaint (how you feel today):

0 1 2 3 4 5 6 7 8 9 10

No Pain — Unbearable Pain

How ofter are your symptoms present? ☐ 0-25% ☐ 26-50% ☐ 51-75% ☐ 76-100%

Can you perform your daily activities? ☐ Yes ☐ No (Describe current activity limitations) ________

HAVE YOU HAD SPINAL X-RAYS, MRI, CT SCAN? ☐ No ☐ Yes Date(s) taken: ________

WHAT AREAS WERE TAKEN? ____________________

Please check all of the following that apply to you: ☐ None Apply

No	Yes	Condition
☐	☐	History of Recent Infection
☐	☐	Recent Fever
☐	☐	HIV/AIDS
☐	☐	Diabetes
☐	☐	Corticosteroid Use
☐	☐	Birth Control Pills
☐	☐	High Blood Pressure
☐	☐	Stroke (date)________
☐	☐	Dizziness/Fainting
☐	☐	Numbness in Groin/Buttocks
☐	☐	Urinary Retention
☐	☐	Aortic Aneurysm
☐	☐	Cancer/Tumor
☐	☐	Osteoporosis
☐	☐	Recent Trauma

No	Yes	Condition
☐	☐	Prostate Problems
☐	☐	Frequent Urination
☐	☐	Pregnant, # of weeks ________
☐	☐	Abnormal Weight ☐ Gain ☐ Loss
☐	☐	Epilepsy/Seizures
☐	☐	Visual Disturbances
☐	☐	Low/Mid Back Pain
☐	☐	Neck Pain
☐	☐	Arthritis
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Nocturnal Pain (pain at night)
☐	☐	Surgeries ________
☐	☐	Medications ________

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

I certify that the above information is complete and accurate. If the health plan information is not accurate, or if I am not eligible to receive a health care benefit through this provider, I understand that I am liable for all charges for services rendered and I agree to notify this doctor immediately whenever I have changes in my health condition or health plan coverage in the future. I understand that my chiropractor may need to contact my physician if my condition needs to be comanaged. Therefore I give authorization to my chiropractor to contact my physician, if necessary.

Patient Signature:____________________ Date:____________

Patient Registration Information

Insurance cards copied ☐

Date: ____________

Account # ____________

Insurance # ____________

Co-Payment: ____________

Please PRINT AND complete ALL sections below!

Name: ______________________________ **e-mail:** ____________________

Last First Initial

Address: ______________________________

____

Home Telephone: ____________

Social Security #: ____________ Driver's License #: ____________

Date of Birth: ____________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Sex: Female ☐ Male ☐

Employer: ____________ Work Telephone: ____________

Full-time ☐

Part-time ☐

Insurance Information

Please present insurance cards to office personnel

Primary Insurance Name: ____________

Name of Insured: ____________ Birthdate: ____________

Insurance # ____________

Group # ____________

Relationship to insured: Self ☐ Child ☐ Spouse ☐ Other ☐

Secondary Insurance Name: ____________

Name of Insured: ____________ Birthdate: ____________

Insurance # ____________

Group # ____________

Relationship to insured: Self ☐ Child ☐ Spouse ☐ Other ☐

Please tell us how you were referred to us: ______________________________

AGONA CHIROPRACTIC CLINIC

Dr. Daniel J. Agona, D.C.

1802 Lincoln Way
White Oak, PA 15131
Phone (412) 678-3844
Fax (412) 346-0203

AUTHORIZATION

Authority is hereby given to **Dr. Daniel J. Agona, D.C.** to furnish to my Attorney, Physician or Insurance Company and their representative, copies of any and all records, reports, notes, correspondence, x-rays, test results, or other material or information relating to my consultation, examination, medical history, diagnosis, or treatment and to permit inspection and examination of tangible materials related to examination, diagnosis or treatment.

I understand that my Attorney, Physician or Insurance Company or their representative may make photocopies of this authorization and I hereby authorize the copy to be valid as the original signed authorization.

____
Patient

NOTICE OF PRIVACY ACT

I hereby acknowledge that I have read and understand the Notice of Privacy Practices of Agona Chiropractic Clinic.

____
Patient

INFORMED CONSENT

I have been informed and consent to treatment.

____
Patient