West-Land Clinic of Chiropractic
1929 Dailey Avenue
Latrobe, PA 15650
Dr. Phillip A. Westerbeck & Dr. Patrick J. Landry

Confidential Patient Information

Patient's Full Name:_____ Date: ____/____/____

Home Phone_____Cell Phone:_____

Mailing Address:_____City:_____State:_____Zip:

E-Mail:_____ Male Female Age:_____

Your email will be used only for office updates and newsletters (it will not be sold or distributed for any other purpose) Date of Birth: ____/_____/____

Occupation:_____Hours / Week____Employer:_____Business Phone:_____

Spouse's Name:_____Employer:_____Business Phone:_____

Emergency Contact:_____ Relationship:_____Phone:_____

Emergency Contact Address:_____City:_____State:_____Zip:_____

How did you hear about our office?_____ If referred, by whom?_____

Insurance Information

Do you have health insurance? Y/N Insurance Company Name:_____

Is Today's Visit Due To a Work Related Injury? Y / N **Auto Accident:** Y / N

Date of Injury: _____

If yes to either question above, please check with receptionist, additional information is needed Have you had previous Chiropractic / Physical Therapy care: Y / N If Yes, for what Problems:_____

Which best desribes your health goals:

- ____ Pain relief only (not interested in correction of problem)
- ____Would like to find the cause of this problem and have it improved or corrected
- ____Wellness / preventative care - just want to stay well and be at optimal health.

There may be some things that your insurance company does not cover, but we have many reasonable and affordable payment options. If you have a problem that we can help, and we decide to accept your case, are you willing to pay out of pocket to reach your health care goals? ____Yes ____No

Patient Signature:_____ Date:_____

Chief complaint: _____
Date of Onset: _____ Was the Onset: Gradual/Sudden Since Onset, has it gotten: Worse/Better/Same
Describe what caused the pain: _____

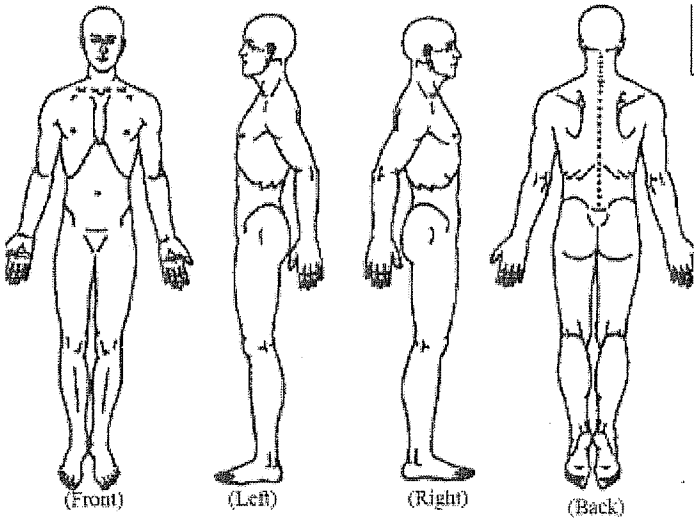
Secondary or related complaint, if any: _____
Date of Onset: _____ Was the Onset: Gradual/Sudden Since Onset, has it gotten: Worse/Better/Same
Describe what caused the pain: _____

Concurrent Health Care:
Are you currently receiving treatment for this problem? Y/N If yes, with whom and what is being done?

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS TO HELP EXPLAIN THE PROBLEM:



Please Mark Areas of Pain using these Codes
X = Pain ==== = Radiating Pain
O = Sharp/Shooting # = Numbness
+ = Dull/Ache * = Tingling

SEVERITY OF PAIN:
List region of pain and circle the number which represents the intensity of your pain.

1. Chief Complaint: 0 1 2 3 4 5 6 7 8 9 10
No Pain Severe

2.Secondary Complaint: 0 1 2 3 4 5 6 7 8 9 10
No Pain Severe

3. Other Complaint: 0 1 2 3 4 5 6 7 8 9 10
If any: _____ No Pain Severe
_____
_____
_____

YOU'RE CHIEF COMPLAINT:

Describe the quality of the chief complaint / pain (circle):
Sharp / Shooting Dull / Ache
Tingling Numbness
Radiating Throbbing
Other: _____

Does any of the following make your pain worse (circle):
Lifting Bending Pushing Pulling
Coughing Sneezing Bowel Movement
Driving Riding Sitting Walking
Prolonged Standing Other: _____

How often are you aware of the pain:
____ Intermittent (less than 25% of time when awake)
____ Occasional (25 - 50% of time when awake)
____ Frequent (50 - 75% of time when awake)
____ Constant (75 – 100% of time when awake)

Does any of the following make your pain better (circle):
Rest Laying down Sitting
Walking Exercise Moving About
Heat / Ice Stretching Medications

Does your pain interfere with your daily activities:
____ Minimal (causes pain but doesn't prevent you from doing any of your normal activities)
____ Mild (causes pain and prevents you from doing a few of your normal activities)
____ Moderate (causes pain and prevents you from doing some of your normal activities)
____ Severe (causes pain and prevents you from doing most or all of your normal activities)

What activities are affected: i.e. (sleeping, working, walking, exercising, family activities, household activities, etc.)

_____

_____

_____

YOUR SECONDARY/RELATED COMPLAINT:

Describe the quality of the chief complaint / pain (circle):

Sharp / Shooting Dull / Ache
Tingling Numbness
Radiating Throbbing
Other: _____

Does any of the following make your pain worse (circle):

Lifting Bending Pushing Pulling
Coughing Sneezing Bowel Movement
Driving Riding Sitting Walking
Prolonged Standing Other: _____

How often are you aware of the pain:

____ Intermittent (less than 25% of time when awake)
____ Occasional (25 - 50% of time when awake)
____ Frequent (50 - 75% of time when awake)
____ Constant (75 – 100% of time when awake)

Does any of the following make your pain better (circle):

Rest Laying down Sitting
Walking Exercise Moving About
Heat / Ice Stretching Medications

Does your pain interfere with your daily activities:

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What activities are affected: i.e. (sleeping, working, walking, exercising, family activities, household activities, etc.)

_____
_____
_____

Present & Past Health, Social and Family History

1. Have you ever experienced your present complaint before: Y/N If yes, when_____

_____

2. Was treatment provided: Y/N If yes, by whom_____ Outcome of treatment: _____

3. Have you **ever** had any **major illness, injuries, broken bones, hospitalizations, or surgeries**? If yes list them:

_____
_____
_____
_____
_____

4. Is there any history of significant family health problems? If yes list them:

_____
_____
_____
_____
_____

5. Weight _____lbs. Have you recently lost or gained weight? Y/N Height _____

6. Do you exercise regularly? Y/N If yes, how many hours a week and what activities:

_____
_____
_____

7. Do you smoke? Y/N If yes, how many packs / day? _____

8. Do you drink alcohol? None Light Moderate Heavy

9. Circle any conditions you have had:

AIDS / HIV	Ear Ringing	Poor Circulation
Allergies	Epilepsy	Prostate Problems
Anxiety / Depression	Headache / Migraine	Rheumatoid Arthritis
Arm/shoulder pain	Heart Disease	Sciatica
Arthritis	Herniated Disc	Seizures
Asthma	High blood pressure	Shingles
Bladder Problems	Insomnia	Sinus Infections
Cancer	Irregular Cycle	Stroke
Chronic Fatigue	Kidney Problems	Thyroid Problems
Deafness	Leg Pain	TMJ
Diabetes	Low back pain	Venereal disease
Digestion Problems	Neck pain	Vertigo/Dizziness
Earache	Osteoporosis	Other: _____

10. Have you had any diagnostic imaging i.e. X-RAYS, MRI, CT scan, Bone Scan, etc. in the past five years? Y/N

If yes, what did you have done?

_____

11. Have you detected any possible relationship of your current complaint with any of the following (circle)?

Muscle Weakness Bowel / Bladder problems Digestion Cardiac / Respiratory
Other: _____

12. Have you tried any self-treatment or taken any medication (over the counter or prescription): Y/N

If yes, explain

_____

_____

_____

_____

13. Women only: Are you pregnant? Y/N If yes, how far along are you? _____

Privacy Protection Policy

This page describes how medical information about **West-Land Clinic of Chiropractic's** patients may be used and disclosed and about how you can access this information. If, after reviewing this information, you have any questions, please contact front desk.

West-Land Clinic of Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information and to provide our patients with notice of the legal duties and privacy practices regarding such protected health information.

Disclosure of Your Health Care Information

Treatment

- We may disclose your health care information to other healthcare professionals within our practice for the purpose of treatment, payment or healthcare operations.

Payment

- We may disclose your health information to your insurance provider for the purpose of payment or health care operations.

Workers' Compensation

We may disclose your health information as necessary to comply with State Workers' Compensation Laws.

Emergencies

We may disclose your health information to notify a family member, or anyone else responsible for your care, in the event of an emergency.

Public Health

As required by law, we may disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure.

Judicial and Administrative Proceedings

We may disclose your health information in the course of any administrative or judicial proceeding.

Law Enforcement

We may disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order or subpoena, and other law enforcement purposes.

Public Safety

It may be necessary to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or to the general public.

Specialized Government Agencies

We may disclose your health information for military, national security, prisoner and government benefits purposes.

Change of Ownership

In the event that **West-Land Clinic of Chiropractic** is sold or merged with another organization, your health information/record will become the property of the new owner.

You're Health Information Rights

- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to have your health information received or communicated through an alternative method or sent to an alternative location other than the usual method of communication or delivery, upon your request.
- You have the right to inspect and copy your health information.
- You have a right to request that **West-Land Clinic of Chiropractic** amend your protected health information.
- You have a right to receive an accounting of disclosures of your protected health information made by **West-Land Clinic of Chiropractic**.
- You have a right to a paper copy of this Notice of Privacy Practices at any time upon request.

PATIENT **PAYMENT** OPTIONS

Our experience has shown that it is wise to have an understanding with our patients as to our office policies and fees. Therefore, this form has been prepared for your convenience and information. We offer several methods of payment for your care in our office (if you are accepted as a patient) and you may choose the plan which best fits your needs. Please read carefully and choose the plan you prefer. This information will enable us to better serve you and help avoid any misunderstandings in the future. If special arrangements are necessary, please consult with the Doctor. Our main concern is your health and well being, and we will do our best to help you!

PLAN 1: PROMPT PAY

Fees are to be paid at the time services are rendered (every visit), unless special arrangements have been made in advance. Cash, Check, Visa or MasterCard.

PLAN 2: WEEKLY or MONTHLY CASH PAYMENT AGREEMENT

For that non-transient, but active patients who qualify, we will extend knowledgeable credit through this plan; however, should you become inactive by discontinuing your care, your entire unpaid balance will be due immediately. This plan applies to all cases, except work injury or auto injury claims.

PLAN 3: INSURANCE

If you have insurance that covers **West-Land Clinic of Chiropractic's** Services and we are willing to accept your insurance, we can bill your insurance directly. Please provide us with your current health insurance card, on or before your second visit. Until we have the completed, correct, and necessary information regarding coverage, you will be required to pay for your care. Most patients are required to pay a co-pay/co-insurance in addition to their yearly deductible. In the event that a payment should come to you, you are expected to bring the endorsed check to us along with the EOB's. The contracted insurance plan is yours, not ours; therefore you are always responsible for your account with us. If you become inactive by discontinuing your care, your account balance is due immediately.

PLAN 4: AUTO/PERSONAL INJURY

You need to supply us with the accident report, your auto insurance information, your health insurance information, liable parties insurance information, accident claim number, accident adjustor contact infoiination, and attorney information if applicable. Until necessary information is gathered and verified or you have retained an attorney, you will be required to pay for your care. If we can accept your case, we will bill your insurance directly. In the event that payment comes to you from the insurance company, or your attorney achieves a settlement, then we expect payment immediately. If you are released from care or non-compliant with the medical recommendations, the account balance is due within 90 days. You are responsible for payment of all services on your account. If payment on your account is not made, the balance will be submitted to a collection agency.

Patient or Legal Guardian Printed Name _____ Patient or Legal Guardian Signature _____ Date _____