Ralph J. Siegenthaler, D.C., Inc.
Mark Zannetti, D.C.

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8692 St Rt 45S
Orwell Ohio 44076
Phone: 440-437-6546

Name: _____ Date: _____

Address: _____ City: _____ St: _____ Zip: _____

Home Ph: _____ Cell: _____ Email: _____

Marital Status: M S W D Birthdate: _____ Ht: _____ Wt: _____ Age: _____

Employer: _____ Occupation: _____

Have you been to a chiropractor before? If so, who? _____

Family doctor: _____ Phone: _____

How were you referred to our office? _____

Past health history

Have you...	Yes	No	If yes, explain briefly
...been hospitalized in the last 5 years?	☐	☐	_____
...had any broken bones?	☐	☐	_____
...had any strains/sprains?	☐	☐	_____
...ever used orthotics?	☐	☐	_____

How is most of your day spent? ☐ Standing ☐ sitting ☐ other _____
How old is your mattress? _____
When was your last physical exam? _____

Are you pregnant? ☐ yes ☐ no ☐ uncertain Nursing? ☐ yes ☐ no

*****Insurance Information*****

Primary Insurance: _____ Secondary (if any): _____

Please check insurance coverage that may apply: _____Major Medical ____Medicare ____ Workers Comp
_____Auto accident Other: _____

AUTHORIZATION AND RELEASE: I authorize payment of insurance benefits directly to this chiropractic office. I understand and agree to allow this office to use my Patient Health Information (PHI) for the purpose of treatment, healthcare operations and coordination of care. I understand that I am responsible for all costs, co-pays of Chiropractic care, regardless of insurance coverage.

Patient Signature: _____ Date: _____
Guardian Signature Authorizing care: _____ Date: _____

Give a brief description of the problem you are currently experiencing:_____

_____

_____

How long have you had this condition? _____ Is it getting worse? Y N

Does it bother you □ work □ sleep □ daily routine □ recreation □ housework □ other_____

What seemed to be the initial cause? _____

Type of pain: □ sharp □ dull □ throbbing □ numbness □ aching □ shooting
□ burning □ tingling □ cramps □ stiffness □ swelling □ other

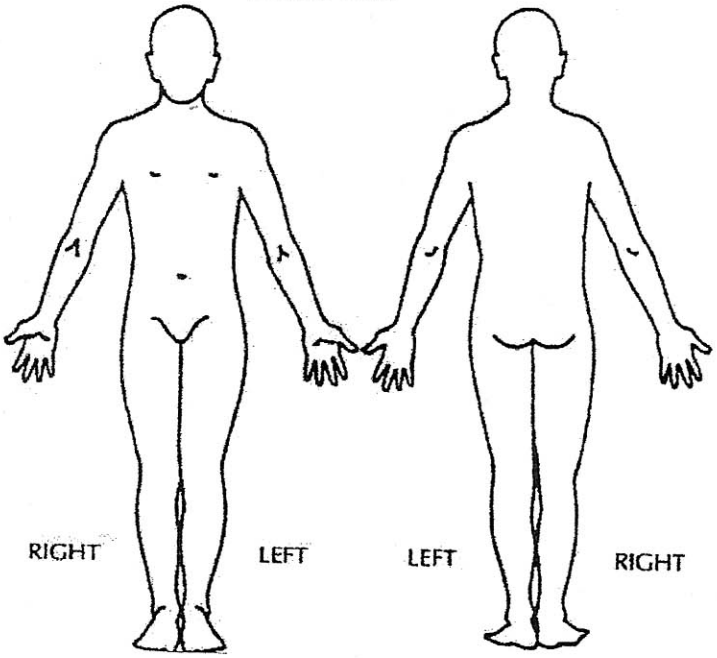
How often do you experience your symptoms? □ constantly □ frequently □ occasionally □ intermittently

Activities/movements that are painful? □ sitting □ standing □ walking □ bending □ lying down

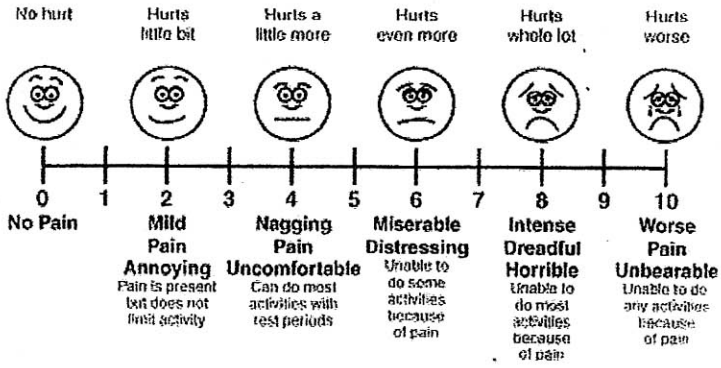
Is the pain worse at... □ daytime □ nighttime

Location of pain... □ fixed □ moving □ radiating

CIRCLE LOCAL REGION OF PAIN.
DRAW A LINE FOR RADIATING PAIN.



Please circle your pain intensity



Do you have other health issues/concerns that we should be made aware of? _____

In general, would you say your overall health right now is... □ excellent □ very good □ good □ fair □ poor

Patient Signature: _____ Date: _____

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Electronic Health Records Intake Form

This form complies with CMS EHR incentive program requirements

First Name:_____ **Last Name:**_____

Email address: _____@_____

Preferred method of communication for patient reminders (Circle one): Email / Phone / Mail

DOB: __/__/____ **Gender (Circle one):** Male / Female **Preferred Language:** _____

Smoking Status (Circle one): Every Day Smoker / Occasional Smoker / Former Smoker / Never Smoked

Family Medical History ***(Record one diagnosis in your family history and the affected***				
Diagnosis (Write in below)	Father	Mother	Sibling: (_____)	Offspring: (_____)
Example: Heart Disease				

Race (Circle one): American Indian or Alaska Native / Asian / Black or African American / White (Caucasian) Native Hawaiian or Pacific Islander / I Decline to Answer

Ethnicity (Circle one): Hispanic or Latino / Not Hispanic or Latino / I Decline to Answer

Are you currently taking any medications? *(Include regularly used over the counter medications)*	
Medication Name	Dosage and Frequency (i.e. 5mg once a day, etc.)

Do you have any medication allergies?			
Medication Name	Reaction	Onset Date	Additional Comments

→I choose to receive a copy of **my clinical summary after every visit** *(These summaries are often blank as a result of the nature and frequency of chiropractic care.)* yes no

→Patient Signature: _____ Date:_____

Ht _____ Wt _____ B/P _____

REVIEW OF SYSTEMS

Patient Name: _____

Have you ever been diagnosed with or experienced any of the following *(check all that apply)*:

Infectious Diseases
- ❑ Chicken Pox
- ❑ Hepatitis
- ❑ Measles
- ❑ Mumps
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Small Pox
- ❑ Scarlet Fever
- ❑ Tuberculosis
- ❑ Whooping Cough
- ❑ Venerial Diseas
- ❑ HIV/AIDS

Musculo-Skeletal
- ❑ Arthritis
- ❑ Headaches
- ❑ Neck Pain
- ❑ Mid Back Pain
- ❑ Low Back Pain
- ❑ Shoulder Pain
- ❑ Arm Pain
- ❑ Thigh Pain
- ❑ Leg Pain
- ❑ Foot Pain
- ❑ Clicking Jaw
- ❑ Walking Problems
- ❑ Rhumatoid Arth.
- ❑ Fibromyalgia
- ❑ Osteoarthritis

Nervous System
- ❑ Attention Deficit
- ❑ Confusion
- ❑ Dizziness
- ❑ Epilepsy
- ❑ Fainting
- ❑ Forgetfulness
- ❑ Hyperactivity
- ❑ Mental Disorder
- ❑ Nervousness
- ❑ Numbness
- ❑ Paralysis
- ❑ Tingling
- ❑ Stress
- ❑ Vertigo

Cardiovascular
- ❑ Angina
- ❑ Chest Pain
- ❑ Hypertension
- ❑ Hypotension
- ❑ Lung Congestion
- ❑ Shortness of Breath
- ❑ Heart Problems
- ❑ Heart Disease
- ❑ Palpitations
- ❑ Stroke
- ❑ Ankle Swelling
- ❑ Varicose Veins

Ears, Eyes, Nose, Throat
- ❑ Ear Infections
- ❑ Dental Problems
- ❑ Halitosis
- ❑ Hearing Difficulties
- ❑ Sinus Congestion
- ❑ Sore Throat
- ❑ Vision Problems

Respiratory System
- ❑ Allergies
- ❑ Asthma
- ❑ Bronchitis
- ❑ Influenza
- ❑ Pleurisy
- ❑ Pneumonia

Urogenital
- ❑ Bladder Infections
- ❑ Excessive Urination
- ❑ Difficult Urination
- ❑ Kidney Problems
- ❑ Incontinence
- ❑ Menstrual Cramping
- ❑ Menstrual Irregularity
- ❑ Painful Urination
- ❑ Sexual Dysfunction
- ❑ Prostate Problems
- ❑ Vaginal Infections
- ❑ Vaginal Pain

Gastro-Intestinal
- ❑ Abdominal Cramps
- ❑ Anemia
- ❑ Acid Indigestion
- ❑ Bloody stool
- ❑ Coughing Up Blood
- ❑ Constipation
- ❑ Crohn's Disease
- ❑ Diabetes
- ❑ Diarrhea
- ❑ Eating Disorder
- ❑ Excessive Appetite
- ❑ Gall Bladder Problems
- ❑ Liver Problems
- ❑ Irritable Bowel
- ❑ Nausea
- ❑ Poor Appetite
- ❑ Thyroid Problems
- ❑ Ulcers
- ❑ Ulcerative Colitis

Other
- ❑ Alcoholism
- ❑ Alzheimer's
- ❑ Broken Bones
- ❑ Cancer
- ❑ Fatigue
- ❑ Concussion
- ❑ Muscular Dystrophy
- ❑ Parkinson's

Lifestyle / Self-Care Issues

Have you ever smoked cigarettes?..... ❑ Yes ❑ No
If yes, _____ packs per day, Smoked for _____ years
Are you still smoking..... ❑ Yes ❑ No
Do you drink caffinated beverages?..... ❑ Yes ❑ No
If yes, _____ cups, cans, etc./day
Do you drink alcohol?..... ❑ Yes ❑ No
if yes, _____ number of drinks / week _____
Previous drug/alcohol problems?..... ❑ Yes ❑ No
Do you manage stress well?..... ❑ Yes ❑ No ❑ Need Help
Do you exercise regularly?..... ❑ Yes ❑ No

Diet Habits and Typical Daily Intake

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Fluids: cups of water: _____ Other Fluids: _____

Current Medications	Dosage	Times/Day

Current Herbs / Vitamins	Dosage	Times/Day

Past Medical History *(circle)*

Aids, HIV	Alcoholism	Allergy
Arthritis	Asthma	Cancer
Cholesterol	Depression	Diabetes
Epilepsy	Heard Disease	Hepatitis
Herniated Disk	Pacemaker	Pinched Nerve
Prostate	Scarlet Fever	Stroke
	Thyroid	Tuberculosis
Tumors	Verereal Disease	High Blood Pressure

Other Illness _____

_____

Surgery _____

_____

Other Injuries/Accidents _____

_____

DOCTOR-PATIENT RELATIONSHIP IN CHIROPRACTIC
INFORMED CONSENT

CHIROPRACTIC
It is important to acknowledge the difference between the health care specialties of Chiropractic, Osteopathy and Medicine. Chiropractic health care seeks to restore health through natural means without the use of medicine or surgery. This gives the body maximum opportunity to utilize its inherent recuperative powers. The success of the Chiropractic Doctor's procedures often depends on environment, underlying causes, physical and spinal conditions. It is Important to understand what to expect from Chiropractic health care services.

ANALYSIS
A Doctor of Chiropractic conducts a clinical analysis for the express purpose of determining whether there is evidence of Vertebral Subluxation Syndrome (VSS) or Vertebral Subluxation Complexes (VSC). When VSS and VSC complexes are fund, Chiropractic adjustments and ancillary procedures may be given in an attempt to restore spinal integrity. It is the Chiropractic premise that spinal alignment allows nerve transmission throughout the body and gives the body an opportunity to use its inherent recuperative powers. Due to the complexities of nature, no doctor can promise you specific results. This depends upon the inherent recuperative powers of the body.

DIAGNOSIS
Although Doctors of Chiropractic are experts in Chiropractic diagnosis, the VSS and VSC, they are not internal medical specialists. Every Chiropractic patient should be mindful of his/her own symptoms and should secure other opinions if he/she has any concern as to the nature of his/her total condition. Your Doctor of Chiropractic may express an opinion as to whether or not you should take this step, but you are responsible for the final decision.

INFORMED CONSENT FOR CHIROPRACTIC CARE
A patient, in coming to the Doctor of Chiropractic, gives the Doctor permission and authority to care for the patient in accordance with the Chiropractic tests, diagnosis and analysis. The Chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problem. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give a Chiropractic adjustment, or health care, if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known or to learn through health care procedures whatever he/she is suffering from: latent pathological defects, illness, or deformities which would otherwise not come to the attention of the Doctor of Chiropractic. The patient should look to the correct specialist for the proper diagnostic and clinical procedures. The Doctor of Chiropractic provides a specialized, non-duplicating health service. The Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regime.

RESULTS
The purpose of Chiropractic services is to promote natural health through the reduction of the VSS or VSC. Since there are so many variables, it is difficult to predict the time schedule or efficacy of the Chiropractic procedures. Sometimes the response is phenomenal.

In most cases there is a more gradual, but quite satisfactory response. Occasionally, the results are less than expected. Two or more similar conditions may respond differently to the same Chiropractic care. Many medical failures find quick relief through Chiropractic. In turn, we must admit that conditions which do not respond to Chiropractic care may come under the control or be helped through medical science. The fact is that the science of Chiropractic and medicine may never be so exact as to provide definite answers to all problems. Both have great strides in alleviating pain and controlling disease.

TO THE PATIENT
Please discuss any questions or problems with the Doctor before signing this statement of policy.

I have read, and understand the foregoing.

_____ DATE

_____ SIGNATURE

RALPH J SIEGENTHALER, DC, INC
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440-442-6969

Consent to use PHI

Acknowledgement for Consent to Use and Disclosure of Protected Health Information

Use and Disclosure of your Protected Health Information

Your Protected Health Information will be used by Ralph J Siegenthaler, DC, Inc or may be disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office.

Notice of Privacy Practices

You should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information may be used or disclosed. It describes your rights as they concern the limited use of health information, including your demographic information, collected from you and created or received by this office. I have received a copy of the Notice of Patient Privacy Policy. _____Patient Initials

Requesting a Restriction on the Use or Disclosure of Your Information

- You may request a restriction on the use or disclosure of your Protected Health Information.
- This office may or may not agree to restrict the use or disclosure of your Protected Health Information.
- If we agree to your request, the restriction will be binding with this office. Use or disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Notice of Treatment in Open or Common Areas

Describe and Notify private areas available upon request

Revocation of Consent

You may revoke this consent to the use and disclosure of your Protected Health Information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected.

By my signature below I give my permission to use and disclose my health information.

Patient or Legally Authorized Individual Signature _____ Date _____

Print Patient's Full Name _____ Time _____

Witness Signature _____ Date _____

EXPIRES IN 3 YEARS