DR. BRANDON BLOOD

Neck & Back

330.479.9193 CENTER

Thank you for choosing The Neck & Back Center.

For your convenience our intake forms are attached below. Please complete the attached forms and bring them to your initial appointment. Please also be sure to bring your health insurance card and drivers license so we can verify your coverage.

Health Insurance: The following information is necessary to submit claims to your insurance company. As a convenience to you we will submit all of your insurance claims and also verify your Chiropractic benefits. It is important for you to understand that your insurance is a contract between you and your chosen insurance carrier. You should take time to familiarize yourself with your individual benefits. It is also important to understand that most insurance companies offer *some* Chiropractic benefits but not all.

Any charges not covered by your insurance company are your responsibility. Payment or co-payment is expected at your office visit. Please make checks payable to 'SYNAPTIC'. For your convenience we also accept Cash, MasterCard, and Visa.

Insurance Referral: If your insurance requires a referral from your primary care physician, this should be obtained prior to your visit. No treatment can be rendered without this **written** referral. Please have your medical doctor fax this referral to our office at (330) 479-9165.

Thank you for your cooperation and if you have any questions, please do not hesitate to ask.

Regards,
Neck & Back Center
4883 Dressler Rd NW
Canton, OH 44718
T: (330) 479-9193
F: (330) 479-9165
www.doctorblood.com

DR. BRANDON BLOOD
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Patient Health and Illness History

Name_____ **Social Security Number** _____-____-_____
(first name) (last name)

Address_____ _____
(Street) (City) (State) (Zip)

Home Phone (_____)_____ **Work Phone (_____)**_____

Mobile Phone (_____)_____ **Email*** _____

Date of Birth ____/_____/_____ **Age**____ **Sex M or F**

Marital Status: S M D W **Children: Y N How Many?**_____

Occupation_____**Employer**_____**Years Employed**_____

Address_____ _____
(Street) (City) (State) (Zip)

Primary Insurance Co. _____ **Policy #** _____
Address _____ **Phone # (_____)**_____

Secondary/Other Insurance Co. _____ **Policy #** _____
Address _____ **Phone # (_____)**_____

Relationship to Insured ____ **Self** ____ **Spouse** ____ **Child** _____**Other**

If Other, please specify _____

Other Insured Name_____

Other Insured Date of Birth ____/_____/_____

Other Insured Employer's Name
_____

Were you referred to our Clinic? If yes, by whom_____

How did you hear about Neck & Back Center? ___Ad __Phone Book ___Brochure ___Sign ___Health Talk Other?_____

I understand and agree that health and accident insurance policies are an agreement between me and my insurance carrier. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I understand and agree that all services not covered by my insurance become by personal responsible for payment. I understand that if I suspend or terminate my care and treatment, all outstanding monies will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.
*By putting your email address here, you agree to sign up for any email communication, including offers, promos, and office updates.

Patient Signature _____ **Date** _____

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CHIEF COMPLAINTS

1. What are your primary complaints? _____

Any additional complaints? _____

2. Is your injury related to work? NO YES If Yes, date of injury ____/____/____

Did you file an injury report with your employer? NO YES

3. Is your injury related to an auto accident? NO YES If Yes, date of accident _____

Was a police report filed? NO YES If Yes, what city and state _____

4. Date when Symptoms began ___/___/___ How did they start? _____

_____

5. How often do your symptoms occur? __occassional__constant __intermittant__frequent

6. How would you rate your pain today? (0=No pain 10=Worst pain)____On average? ____

7. Are you getting: better worse same Have you had this in the past? Y N

8. Are your symptoms stopping you from doing any activities, either work or recreation?

Please explain

_____

_____

9. If your complaint includes pain, is it aggravated by?___ coughing ___ sneezing ___neck movement ___straining at the stool ___reaching ___lifting ___bending ___sitting ___standing ___walking

10. Is there anything that relieves the symptoms?_____

11. Have you had treatment for this condition? If yes, with who and what did they do?

_____

_____

12. Since your symptoms began, have you noticed a change in <u>bowel function</u> or <u>bladder function</u>? (Please Circle one)

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GENERAL HEALTH

Have you ever had any problems with any of the following? (Describe where appropriate)

A. General: Y N
___normal ___fatigue ___weakness ___fever ___loss of sleep ___chills ___weight changes

__night sweats

B. Neurologic Y N
___headache ___dizziness ___fainting ___convulsions ___nervousness ___other_____

C. Eyes Y N_____

D. Ears Y N_____

E. Nose Y N_____

F. Mouth/Throat Y N_____

G. Skin Y N_____

H. Heart/Lungs Y N_____

I. High BP/Stroke Y N_____

J. Breasts Y N_____

K. Genitourinary Y N Bladder Prostate Hormone Therapy Other_____

L. Endocrine Y N Diabetes Thyroid Other_____

M. Psychological Y N_____

N. Cancer Y N_____

O. Digestive Issues Y N_____

Do you smoke? Y N If yes, _____packs per day

Alcohol/Drug use? Y N If yes, how much_____

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PAST MEDICAL HISTORY

1. Have you been to a chiropractor before? Y N If yes, when and who?

_____

2. Do you have a family physician? Y N If yes, who? _____
Family Physician's address and Phone number:

_____

3. When was your last physical exam? _____

4. Do you have any images, (x-ray, MRI, CT scan) of your spine or area of complaint? Y N

If Yes; what was performed, where, and when:

X-Ray_____

MRI_____

CT _____

Other_____

5. Have you been hospitalized in the last 5 years? Y N If Yes, please explain?

_____

6. Have you had surgery in the last 5 years? Y N If Yes, please explain?

_____

7. Have you had a serious accident in the last 5 years? Y N If Yes, please explain?

_____

8. Please list any medications you are currently taking, if none please indicate NONE? (you may attach a separate sheet)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

9. Are you taking any vitamins or supplements?

_____ _____
_____ _____
_____ _____
_____ _____

10. Do you have any drug allergies or any other allergies?

_____ _____

_____ _____

FAMILY HEALTH AND ILLNES HISTORY

Please tell us if members of your immediate family are living and if they have any major health problems.

Cancer_____**Diabetes**_____

Heart Disease_____**Stroke**_____

High Blood Pressure_____**Arthritis**_____

Alzheimer's_____**Other**_____

Are you aware that the above mentioned diseases all have the same underlying cause? Y N

Mother **Alive** **Health Problems**_____

Deceased **Age**_____ **Cause of Death**_____

Father **Alive** **Health Problems**_____

Deceased **Age**_____ **Cause of Death**_____

Sibling **Alive** **Health Problems**_____

Deceased **Age**_____ **Cause of Death**_____

Sibling **Alive** **Health Problems**_____

Deceased **Age**_____ **Cause of Death**_____

Sibling **Alive** **Health Problems**_____

Deceased **Age**_____ **Cause of Death**_____

Authorization to Release Records to my Family Physician or Specialist

I _____ authorize Dr. Brandon Blood, DC, DAAPM and The Neck & Back Center to release my records from the center to _____, my Family Physician as well as to _____, the Specialist that I have seen for my condition (if applicable).

_____ _____

Patient Name Patient/Guardian Signature Date

Informed Consent to Care at The Neck & Back Center

Please read carefully and initial in the box by each statement.

☐ I agree and understand that it is not uncommon that patients can have some increased discomfort after an adjustment. If this happens to me, I can apply ice to the area and rest it. If I am concerned about this discomfort or develop any new symptoms I can call the clinic and ask questions. If I am out of town or are unable to contact the doctor, I can present myself to the emergency room.

☐ I agree and understand that if any tests are performed outside of this office (lab tests or other diagnostic procedures) I understand that the doctor will notify me of the results on my next scheduled appointment.

☐ I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and, if necessary, diagnostic x-rays, on me by the doctor of chiropractic named below and/or anyone working in this clinic authorized by the doctor of chiropractic.

☐ I agree and understand that the results of chiropractic care are not guaranteed and I may ask the doctor of chiropractic the purpose of chiropractic adjustments and procedures done in this clinic.

☐ I agree and understand and am now informed that, as in all health care, in the practice of chiropractic there are some very slight risks to treatment, including, but not limited to, muscle strains and sprains, disc injuries, and strokes. I do not expect the doctor to be able to anticipate and explain all risks and complications and I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known, is in my best interests.

☐ I have read the above consent and it is indicated by my initials next to each statement and by doing so I agree to the above named procedures. I understand and agree that I do not have to sign this consent prior to speaking with the doctor if I have any questions or concerns, however I know this consent must be signed prior to beginning care. I intend this consent form to cover the entire course of treatment for my present condition and for any future conditions for which I seek treatment.

_____ _____

Patient Name Patient/Guardian Signature Date

Dr. Brandon Blood is the Chiropractic Physician at this Clinic.

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Dr. Brandon Blood
Neck & Back Center
4883 Dressler Rd NW
Canton, OH 44718
(330) 479-9193
(330) 479-9165 (Fax)

Authorization for Release of Medical Information

I _____request and authorize_____

to release_____ records to The Spine Center at Hills and Dales to help them in determining my care.

Please Fax Records to: Dr. Brandon Blood, DC, DAAPM

Fax Number: (330) 479-9165

Patient Signature: _____ Date of Birth: _____

Social Security Number: _____

General Health Questionnaire

How old, in terms of age, do you feel? _____

How old, in terms of age, would you like to feel again? _____

On a scale of 1 to 10, 10 being the most, how much do you care about your health?___

Is your current health situation, including your pain, preventing you from enjoying anything in particular in your life? _____

_____

_____

_____

If there is one thing that you would like to be able to do again, what would it be?

_____

_____

_____

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Missed Appointment Policy

There is a $45.00 charge for missed appointments without a 24-hour notice. This charge is the patient's responsibility and cannot be billed to the insurance company. Missed appointment fees must be paid before scheduling subsequent appointments. Patients who frequently miss appointments without 24 hours notice may be required to make a deposit to hold future appointments.

If multiple appointments are missed without notification, we may recommend that you seek treatment at another facility. If continued treatment is requested in our office after multiple missed appointments, we will require signed authorization to charge any and all missed appointments to a credit card, which we keep on file. In fairness to our patients who do pay for service, after reasonable efforts on our part to obtain payment, we will solicit the services of a collection agency if necessary.

Signature: _____
Date: _____