Welcome to the Center of Chiropractic Orthopedics Dr.
Mark J. Sperbeck, D.C., D.A.C.O.
4223 Harrison Avenue, Cincinnati, OH 45211
(513) 481-7800

PATIENT INFORMATION

Date__________________

Legal name____________________________________

SS #____

Date of Birth / /   Age_ Gender: Male   Female

Home Phone _________________________________

Cell Phone____________________________________

Work Phone _________________________________

Email Address________________________________

Address_______________________________________

City____

State__________________   Zip__________________

Employer_____________________________________

Occupation____________________________________

Spouse's name_________________________________

Spouse's Employer_____________________________

Referred by___________________________________

Family physician_______________________________

May we contact them regarding your health? Y or N

INSURANCE INFORMATION

Name on account______________________________

Birthday for account holder_____________________

Relationship to patient_________________________

EMERGENCY CONTACT

Name____

Relationship__________________________________

Home # _____________________________________

Work/Cell #___________________________________

Due to HIPPA (privacy) regulations we are giving you the option, to provide in writing, your permission for our office to share your medical and/or billing information with the person(s) you assign.

_______I do not wish to have this option.

______I authorize the Doctors and/or staff to discuss my medical information with the following names-

Name________________________________Relationship___________________Number______________________

Name________________________________Relationship___________________Number______________________

Signature of Patient (or Guardian if under 18)_____________________________ Date_____________________

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PRACTICE'S REQUIREMENTS

The Practice:

- Is required by federal law to maintain the privacy of your PHI and to provide you with this privacy notice, detailing the Practice's legal duties and privacy practices with respect to your PHI.
- The practice adheres to Ohio law in those instances where Ohio law does not conflict with the federal law.
- Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of you PHI that it maintains.
- Will distribute any revised Privacy Notice to you prior to implementation ➢ Will not retaliate against you for filing a complaint.

Effective Date:
This notice is in effect as of 04/14/03

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of The Center of Chiropractic Orthopedics' Notice of Privacy Practices.

____ ______________________

Signature of patient or patient representative Date

AGREEMENT TO PAY FOR TREATMENT

The patient and responsible party listed below hereby agree to pay all charges submitted by this office during the course of treatment for the patient. If the patient has insurance coverage with a managed care organization with whom this office has a contractual agreement, the patient and/or responsible party agree to pay all applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party agree to pay ALL applicable co-payments and deductibles which arise during the course of treatment for the patient. The patient and/or responsible party also agree to pay for treatment rendered to patient which is not considered to be a covered service by third party insurers or payors.

____ ____________________

Signature of patient or patient representative Date

TERMS OF ACCEPTANCE

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

Chiropractic has only one goal. It is important that each patient understands both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment.

Adjustment: The specific application of forces to facilitate the body's correction of vertebral subluxation. Our chiropractic method of correction is by specific adjustments of the spine.

Health: The 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 vertebra in the spinal column which causes alteration of nerve function and interference to the transmission of mental impulses, resulting in a lessening of the body's innate ability to express its maximum health potential.

We do not offer diagnosis or treat any disease. We only offer to diagnose either vertebral subluxation or neuromusculoskeletal conditions. However, during the course of a chiropractic spinal examination we encounter nonchiropractic or unusual finding, we will advise you. If you desire advice, diagnosis or treatment for those findings, we will recommend that you seek the services of another health care provider.

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 major interference to the expression of the body's innate wisdom. Our only method is specific adjusting to correct vertebral subluxation. However, we may use other procedures to help your body hold the adjustments.

I (please print)________________________________ read fully and understand the above statement

All questions regarding the doctor's objective pertaining to my care in this office have been answered to my complete satisfaction.

Therefore, I accept chiropractic care on this basis.

____ ____________________

Signature of patient Date

CONSENT TO EVALUATE AND ADJUST A MINOR CHILD

I___________________________________ being the parent or legal guardian of_____________________________
Have read and fully understood the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

PREGNANCY RELEASE

This is to certify that to the best of my knowledge I am not pregnant and the Doctor and his associates have my permission to perform an x-ray evaluation. I have been advised that x-rays can be hazardous to an unborn child.

Date of last menstrual cycle____________________

Please Sign:________________________________ Date:_______________

PATIENT CONDITION

Reason for visit

____

____

____

When did your symptoms start?__________ How did your problem start?_________________________

Rate your level of pain today: (circle one--0 no pain, 10 severe pain) 0 1 2 3 4 5 6 7 8 9 10

Is Your Condition: (Please circle) Getting better Staying the same Getting worse

Is your pain: Constant (100% of day) Occasional (50%) Frequent (75%) Intermittent (25%)

Describe the pain:

- Sharp/ Stabbing
- Burning
- Dull ache
- Throbbing
- Shooting
- Numbing/Tingling

Does it interfere with:

- Work
- Daily activity
- Sleep
- Nothing
- Recreation

What makes you worse:

- Sitting
- Standing
- Walking
- Bending
- Lying down

What makes you better:

- Nothing
- Rest
- Activity
- Heat
- Cold
- Medication

What test have you had:

- X-Rays
- MRI
- EMG
- Ultrasound
- Lab work

What treatment have you had:

- Drugs
- Physical Therapy
- Surgery
- Nerve Blocks

Has the treatment helped? Yes No Have you ever had this problem before? Yes No

LIST OF HOPITALIZATIONS, SURGERIES, MEDICATIONS & ALLERGIES

Falls/Fractures:____

Hospitalizations/Surgeries:____

Medications/Supplements____

Allergies:____

SOCIAL HISTORY

Marital Status (Please circle): Married Single Divorced/ Separated Widowed

Use of alcohol (Please circle): Never Rarely Moderate Daily

Use of tobacco (please circle): Never Rarely Moderate Daily

Work activity (please circle): Light labor Heavy labor Sitting Standing

Exercise Activity (please circle): None Light Moderate Strenuous

FAMILY HISTORY

	Living	Rheumatoid Arth.	Cancer	Diabetes	Heart problems	Back problems
Father:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Mother:	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No
Sibling(s):	Yes No	Yes No	Yes No	Yes No	Yes No	Yes No

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

(Check all that apply to you)

- Bad general health
- Recent Weight Change
- Hard of hearing
- Sinus Problems
- Nose Bleeds
- Glasses or contact lens
- Blurred/ double vision
- Fever
- Fatigue
- Ringing in the ears
- Swollen glands
- Cancer Fibromyalgia
- Chronic fatigue
- Headaches
- Vertigo
- Sore Throat
- HIV/AIDS
- Systemic Lupus
- Eye disease/Injury
- Heartburn
- Nausea/Vomiting

- Seizures or Epilepsy
- Numbness/Tingling
- Tremors
- Stroke
- Joint pain/Stiffness
- Joint swelling
- Arthritis
- Osteoporosis
- Kidney stones
- Cough
- Congestions
- Wheezing
- Asthma
- Emphysema
- Pneumonia
- Anxiety/Depression
- Mood Swings
- Chest pain/ Palpitations
- Dizziness/Fainting
- Shortness of breath
- Heart attack
- Swelling in hands/feet
- High blood pressure
- High cholesterol
- Congestive heart failure
- Difficulty sleeping
- Memory loss
- Slow to heal after cuts
- Bleed or bruise easily
- Anemia
- Enlarged glands
- Excessive thirst
- Heat/cold intolerance
- Skin becoming drier
- Diarrhea/Constipation
- Blood in stools
- Gall bladder problems
- Liver problems
- Ulcers
- Pain/difficulty urinating
- Blood in urine
- Incontinence
- Diabetes
- Thyroid Disorder
- Rash/Sore
- Lesions
- Breast pain or lump
- Dermatitis/Eczema
- Food allergies
- Airborne allergies
- Systemic Lupus

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic of any changes in my medical status.

_______________________________________ ________________________

Signature of patient or patient representative Date