ADVANCED CHIROPRACTIC OF PHILADELPHIA
CLIENT INTAKE

PATIENT INFORMATION						
First Name:	Last Name:		Middle Initial:	Today's Date:		
Is this your legal name? Yes No	If no, what is your legal name?		Gender:	Date of Birth:		
Mailing Address:	City:		State:	Zip:		
Email Address:	Home Phone:		Cell Phone:			
Social Security Number:	Marital Status: S M DP D SEP W		Partner's Name:			
Occupation:	Employer:		Work Phone:			
Drug Allergies:	Do you smoke? Yes No	How often?	Weight:	Height:	Race/Ethnicity:	
How did you hear about us?	Physician: Family/Friend: Online:					

INSURANCE INFORMATION					
Primary Insurance Company:	Member ID:		Group Number:		
Policy Holder's Name:	Date of Birth:	Relationship To Policy Holder?	Self	Spouse / Partner	Child / Dependent
Address, if different from above:	City:		State:	Zip:	

EMERGENCY CONTACT		
In the event of an emergency, who would you like us to contact about your care?		
What is the best way to contact this person?	Home Phone:	Cell Phone:

ADMINISTRATIVE CHECK LIST **(Please leave blank for office use)**												
Patient Info Complete:		Y N	Initial	Insurance Info Complete:		Y N	Initial	Card copied:		Y N	Initial	
Blood Pressure:		Y N	Initial	Emergency Contact Listed:	Y N	Initial	Added to Mailing List:			Y N	Initial	
Notes:												

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WHAT BRINGS YOU TO OUR OFFICE TODAY?								
Please describe your primary complaint and the symptoms you experience:								
When did this complaint begin?								
Which words best describe your pain? (Check all that apply)	Sudden	Gradual	Progressive	Sharp	Dull	Ache	Burn	Throb
What makes your symptoms increase?								
What relieves your symptoms?								

Do you experience numbness?	Yes	No	Where?
Do you experience tingling?	Yes	No	Where?

How often do you experience your symptoms? (Check one)	100%	75%	50%	25%	10%

On the scale below, please mark a line that best describes the intensity of your pain:

No Pain_____Unbearable pain

HAVE YOU HAD PREVIOUS CHIROPRACTIC CARE? (Check one)	Yes	No

When?	Why did you seek treatment?	Who did you see and where was their office?

HAVE YOU SOUGHT ALTERNATIVE TREATMENT FOR YOUR CONDITION? (Check all that apply)						
Physician	Specialist	Massage	Exercise	Surgery	Prescriptions	Acupuncture
Kind/Other:						

Physician's Name:	Specialist's Name:

Have you had any surgeries for this or a related condition? (Please list type, surgeon's name, dates, and proscriptions.)

PLEASE LIST ALL MEDICATIONS, INCLUDING VITAMINS, YOU CURRENTLY TAKE:			
Kind / Dose:	Frequency:	Kind / Dose:	Frequency:
Kind / Dose:	Frequency:	Kind / Dose:	Frequency:
Kind / Dose:	Frequency:	Kind / Dose:	Frequency:

PATIENT SIGNATURE

By signing below, I certify that my personal information and my medical history written above are true and correct to the best of my knowledge.

_____ _____

Signature Date

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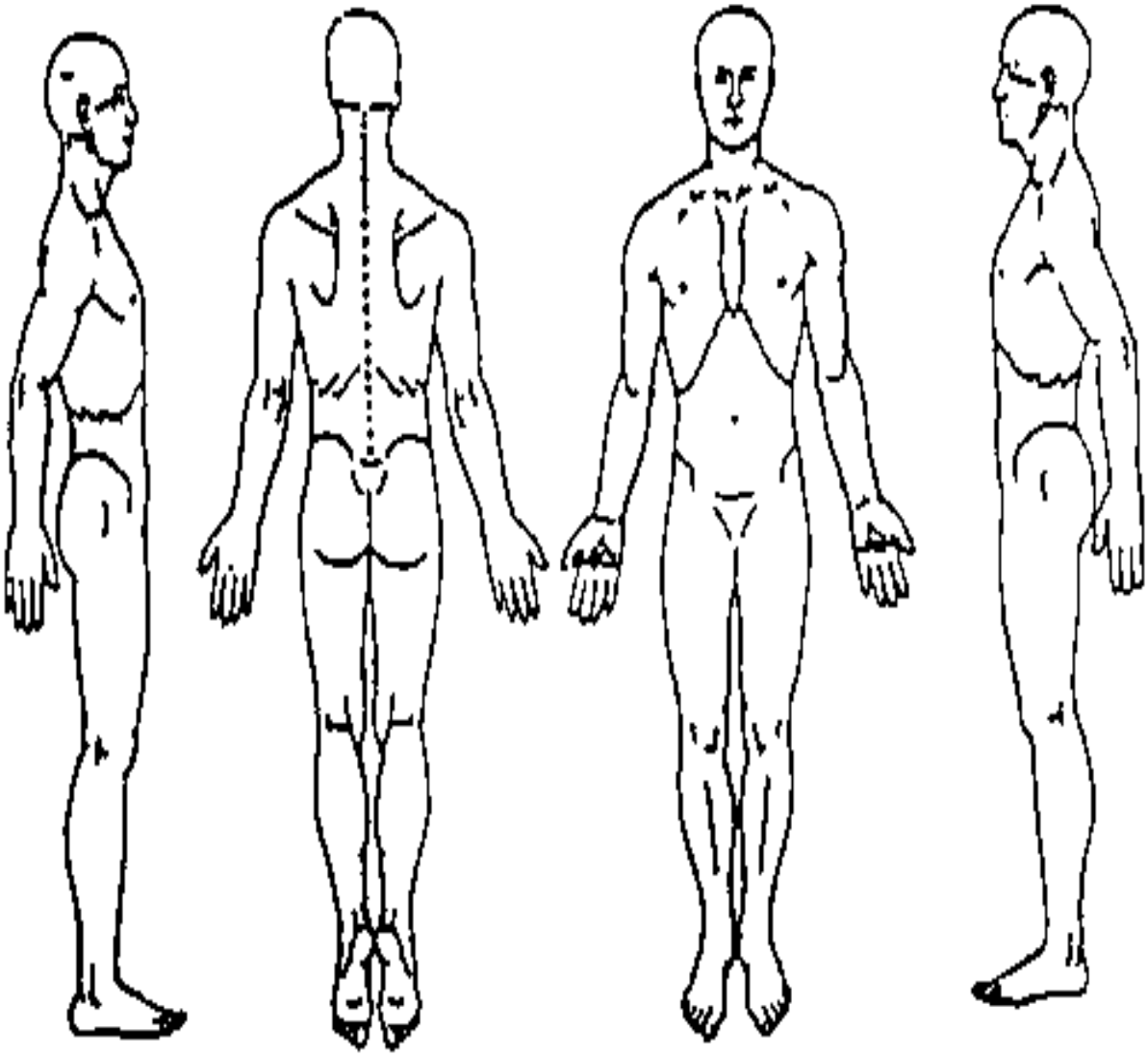
PAIN DIAGRAM

On the body maps below, please mark your complaint areas using the following symbols to describe your condition:

PPP Where you experience PAIN
NNN Where you experience NUMBNESS
TTT Where you experience TINGLING
BBB Where you experience BURNING
CCC Where you experience CRAMPING



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Statement of Privacy

At Advanced Chiropractic of Philadelphia, we value your privacy and we strive to protect your confidential personal and medical information. **We are required by law to provide you notice of your patient rights, our legal obligations and our privacy practices with respect to the information you entrust to us. Throughout the course of your care with Dr. Alexander Jamieson, we may use and/or disclose personal and medical information about you** in the following ways:

- **For Treatment**: We may use or disclose your personal and medical information, including clinical records, to another health care professional or medical practice if it is necessary to seek consult or refer you for further diagnosis or treatment.
- **For Payment**: We may use or disclose your personal and medical information, along with billing records, to your insurance provider (including your Employer/Human Resources) for the purpose of benefits assessment, payment requirements, or related health insurance operations.
- **For Health Care Operations**: We may use or disclose your personal and medical information to a third party for the following reasons
    - As required by law enforcement officials or in legal proceedings. (For example, by court order, subpoena, or to comply with such an investigation.)
    - To worker's compensation or similar programs in order to process claims.
    - If we provide health care services to you in an emergency situation.
    - Other uses and disclosures as required by local, state, and federal law.
- **For Marketing**: *We will never use or disclose your **medical information** for marketing purposes*. We may use or disclose your personal information for the purpose of appointment correspondences, such as leaving voicemail messages at the phone numbers you provide. We may also use or disclose your personal information to provide care alternatives and / or to suggest health-related information that may be of interest to you via our email newsletter/s.

You have the right to obtain a copy of all personal and medical information in your patient file, including a print copy of this privacy statement.
You have the right to refuse authorization of this office to disclose your personal or medical information.
You have the right to request a limitation on the use or disclosure of your personal or medical information.
You have the right to amend the personal and medical information you provide to us.
You have the right to register a complaint regarding our privacy statement, use and disclosure practices, to to request further information. All questions or complaints should be directed *in writing* to Dr. Alexander Jamieson of Advanced Chiropractic of Philadelphia. You may also file a complaint at: www.HHS.gov/ocr/HIPPA

*Any request, amendment or refusal must be rendered **in writing** to Advanced Chiropractic of Philadelphia.* We reserve the right to dispute any request, amendment or refusal. Use or disclosure of your personal and medical information, other than as outlined above, will be made only upon written authorization. Further, we maintain information about your personal and medical information for seven (7) years from the date of your first appointment, or as long as the information remains in our files.

This notice is effective as of December 15, 2012. This notice and any alteration or amendments made hereto will expire seven (7) years from the date of your first appointment or from the date upon which your client file was first created in our medical records system.

My signature acknowledges that I have read this notice and received a copy for my records as per request.

Name (Print):_____

Signature:_____ Date:_____