BORIO CHIROPRACTIC HEALTH CENTER

Health Questionnaire

Name _____ Home Phone ____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____ Date of Birth ____/___ /____ Male/Female

Age _____ SS# _____ Email _____

Occupation _____ Marital Status: M W D S Spouse Name_____

No# of Children _____ Name of Children _____

Insured's Name (if other than self) _____ Birth date_____

1. Many patients are referred to our office by family or friends. Who can we thank for referring you? _____

2. Science tells us your spine like your teeth need to be cared for regularly. When was your last complete spinal examination including x-rays? _____ ☐ Never

How often do you get adjusted by a chiropractor? ☐ Frequently ☐ Only when you hurt ☐ 1 x monthly ☐ Never

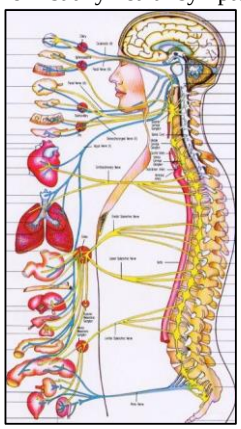
3. Over time, spinal misalignments will cause arthritis and degeneration which results in grinding or cracking to be heard when you move your neck or back, as well as loss of Nerve Health. Do you hear these sounds when you move your head or neck? ☐ Yes ☐ No

4. If your spine is out of alignment for a long time it can make you feel like you need to twist, stretch, or crack your neck or back.
Do you often feel the need to crack or pop your neck or lower back? ☐ Yes ☐ No

5. Poor posture leads to poor health and early death. How would you rate your posture?
Poor 1 2 3 4 5 6 7 8 9 10 Excellent

6. Stress causes your spine to misalign and accelerates spinal damage. Rate your stress level.
None 1 2 3 4 5 6 7 8 9 10 Intense

7. Subluxation (misalignment) of your spine will lead to health problems in your body.
Please **CIRCLE** or list any health symptoms or health complaints you are experiencing.



Allergies
Thyroid
Heart Disease
Asthma
Diabetes I/II
Menstrual Pain
Digestive (Constipation/IBS)

Headaches/Migraines
Neck Pain L/R
Arm Pain L/R
Mid Back Pain
Low Back Pain
Leg Pain

Anxiety/Depression
Auto-Immune Disease
Allergies: _____

8. Prescription medications can cause various side effects, hide the severity of health problems, and hinder the body's ability to heal.
What medications are you currently taking? (Use back if necessary)
1. _____ 2. _____ 3. _____

9. Please list any surgeries you have had: _____

10. Do You Smoke? ☐ Yes ☐ No

11. Spinal health is vitally important to ensure you and your baby are healthy. Are you pregnant? ☐ Yes ☐ No

12. Improper sleeping positions can cause spinal misalignment. What sleeping position do you sleep in:
☐ Back ☐ Stomach ☐ R Side ☐ L Side

13. Exercise level: Never 1 2 3 4 5 6 7 8 9 10 Often 14. Are you? ☐ Right-Handed ☐ Left-Handed

15. Please list vitamins/supplements you take: _____

19. Care is important to restore your health, are you committed to following the recommendations necessary to correct your problem?
☐ Yes ☐ No

Patient Signature (Parent/Guardian): _____ Date: _____

The above information is true and accurate to the best of my knowledge

BORIO CHIROPRACTIC HEALTH CENTER

Informed Consent for Chiropractic Care

When a patient seeks chiropractic health care and we accept a patient for such care, it is essential for both of us to be working for the same objective. It is important that each patient understand both the objective(s) and the method(s) that will be used to attain this objective. This will prevent any confusion or disappointment. You have the right, as a patient, to be informed about the condition and the recommended care to be provided so that you make the decision whether to undergo chiropractic care after being advised of the known benefits, risks, and alternatives.

Chiropractic is a science, philosophy and art which concerns itself with the relationship between the spinal structure and the health of the nervous system. As chiropractors we understand that health is a state of optimal physical, mental, and social well-being, not merely the absence of disease or infirmity.

One disturbance to the nervous system is called a vertebral subluxation. This occurs when one or more of the 24 vertebrae in the spinal column become misaligned and/or do not move properly. This causes an unhealthy change to nerve function and interference to the nervous system. This may result in pain and dysfunction or may be entirely asymptomatic.

Subluxations are corrected and/or reduced by a chiropractic adjustment. An adjustment is the specific application of force to correct and/or reduce vertebral subluxation. Our chiropractic method of correction is by specific adjustments to the spine. Adjustments are done by hand where the doctor will put pressure on the specific segment(s) of the spine to adjust the vertebrae into a better position.

If at the beginning or during care we encounter a non-chiropractic or unusual findings, we will advise you of those findings and recommend some further testing or refer you out to another health care provider.

Chiropractic care has been proven to be very safe and effective. It is not unusual however, to be sore after your first few corrective adjustments. Although rare it is possible to suffer from other side effects, i.e., muscle spasms, stiffness, rib fracture, headache, dizziness, and stroke.

All questions regarding the doctor's objective to my care in this office has been answered to my complete satisfaction. The benefits, risks and alternatives of chiropractic care have been explained to me to my satisfaction. I have read and fully understand the above statements and therefore accept chiropractic care on this basis.

Print Name Signature Date

Consent to evaluate and adjust a minor child

I, _____ being the parent or legal guardian of _____ have read and fully understand the above Informed Consent 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 above doctor and his/her 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: _____

Signature Date

BORIO CHIROPRACTIC HEALTH CENTER

Patient Name: _____ File: _____

Are you using insurance? Please circle: Yes No

Who is the primary subscriber? Their Name: _____ Their Date of Birth _____

What is your relationship to Insured? Please circle: Self Spouse Child Other

Standard Waiver of Liability:

I understand I am financially responsible for any charges incurred at this office, for those patients' using insurance, this would include co-pays, deductibles, and charges denied or not covered by my insurance company.

I realize my care may be subject to pre-authorization by my insurance company, and I accept any responsibility for charges which may not be approved. My insurance company will review any/all documentation submitted by Borio Chiropractic for review for medical necessity, however, final determination is based upon my insurance company's medical guidelines. Insurance policy limitations are per individual insurance policy plans, as are co-payments, coinsurance, deductibles, referrals, etc.

I understand this office agrees to notify me as soon as possible whether my care is approved or denied by my insurance company. I further understand my initial visits may be denied and this may be beyond the office's ability to notify me prior to rendering acute care, while waiting for insurance coverage approval. These charges will be my responsibility if denied by my insurance company.

Note: Our office does not bill secondary insurance carriers.

I understand this office will require payment from me for any services not covered by my health insurance plan. Any payment due beyond 30 days is subject to late fees, interest at 1.5% per month and collection agency fees. I agree to pay all collection costs associated with collecting said debt, including, but not limited to attorney fees of 25% (twenty-five percent), together with the costs and disbursements of the action.

Assignment of Benefits:

I hereby authorize my insurance benefits to be paid directly to Dr. Joseph Borio.

I have read this document and understand my obligations for payment for care in the absence of insurance coverage.

_____

Signature (Patient, or Parent/Guardian of Patient) Date:

Release of Medical Records:

I give my permission for Dr. Borio to request medical information for other medical facilities that may help the doctor to accurately assess and treat my current condition

_____

Signature (Patient, or Parent/Guardian of Patient) Date

BORIO CHIROPRACTIC HEALTH CENTER

Wellness Begins Here
(315) 699-1441

This is to acknowledge my approval to allow Borio Chiropractic P.C. to take my picture for the sole use of patient file identification only. **This photo will never be used for any purpose other than patient identification, nor will this photo or any information be shared with any outside source.**

_____

Patient Signature

_____

Date

Our purpose is to educate and adjust families toward optimal health with natural chiropractic care

BORIO CHIROPRACTIC HEALTH CENTER

Notice of Privacy Practices

This notice describes how health information about you is stored, may be used, and or disclosed.

How We Store Your Information: Patient information is stored here in the office on a secure server with no outside access. X-Rays images are also stored on the server and the hard copies of your file and X-Rays are stored here in our office. All storage is secure and meets or exceeds HIPPA requirements and regulations.

What We Do Not Do with Your Information: Information about your financial situation, medical conditions, and care that you provide to us in writing, via email, on the phone (including information left on voice mails), contained in or attached to applications, or directly or indirectly given to us, is held in strictest confidence.
We do not give out, exchange, barter, rent, sell, lend, or disseminate any information about our patients to anyone who receives our services. Know that all patient information is considered confidential, is restricted by law, or has been specifically restricted by a patient/client in a signed HIPAA consent form.

How We Do Use Your Information: Information is only used as is reasonably necessary to process your care, billing to an insurance company or to provide you with health or services which may require communication between Borio Chiropractic Health Center and health care providers, insurance companies, and other providers necessary to: verify your medical information is accurate; determine the type of medical supplies or any health care services you need including, but not limited to.
or to obtain or purchase any type of medical supplies, devices, medications and insurance.

No Patients information and no identifying information (photos, addresses, phone numbers, contact information, last names, or uniquely identifiable names) will ever be used without patient's express written advance permission.

Print Patient Name Signature Date

Borio Chiropractic Health Center
8212 Brewerton Road, Cicero, NY 13039
(315)-699-1441 www.boriochiropractic.com

BORIO CHIROPRACTIC HEALTH CENTER

Pediatric Consultation

Child's Name _____ Date _____

The majority of children have experienced hundreds of impacts that could cause vertebrae to become misaligned or subluxated. What we need to do now is discover several of the traumas your child has suffered.

What was your child's birth like? Easy/Stressful/Complicated/Surgical

How long was the entire labor? _____ How long did you actually push for? _____ Were you induced? 0 Yes 0 No Nerve block? 0 Yes 0 No C-Section? 0 Yes 0 No Was there any pulling on the head? 0 Yes 0 No 0 Mid-wife OBGYN 0 Forceps or vacuum extraction

Science has shown that 47% of all children fall on their heads by the age of one and have at least 200 major falls by the age of 5 years old.

When was your child's most recent fall? _____ Was any care given? 0 Yes 0 No Was he/she checked by a chiropractor for subluxation? 0 Yes 0 No

And the fall before that? _____ Any care given? 0 Yes 0 No Chiropractic adjustment? 0 Yes 0 No

What sports or recreational activities does your child do? _____ When was your child's most recent stress, strain or injury while doing these activities? _____ Any care given? 0 Yes 0 No Chiropractic adjustment? 0 Yes 0 No

Has your child ever been involved in a motor vehicle accident as a passenger? 0 Yes 0 No Briefly describe:
When/Details? _____ Child seat? 0 Yes 0 No
Seat belt? 0 Yes 0 No Front or back seat? 0 Yes 0 No
Was care given? 0 Yes 0 No Chiropractic adjustment? 0 Yes 0 No

This information is important. Thank you for explaining your child's history of accidents and traumas. This will help the doctor better understand where the spine is damaged or subluxated. What we need to do now is ask you a few questions regarding your child's current health concerns.

Does your child have any health concerns? 0 Yes 0 No What are they? _____

If so, how long have they been present for? _____
Subluxated vertebra will cause irritation to nerve fibers affecting organs and tissue leading to sickness. Are there any other conditions you child is or was experiencing? 0 Yes 0 No
How long and details? _____
Depending on where and the degree of the subluxated vertebra, nerve pressure can be constant or occasional. How often does your child have this condition(s)? _____ Does your child take multi-vitamins regularly? 0 Yes 0 No What other supplements does your child take?
_____

Please list all medications your child takes: _____

Signature Parent or Guardian: _____ Date: _____