

Welcome to West Chester Acupuncture and Chiropractic

Dr. Julie Hilbert, DC, FIAMA, Dipl.Ac. – Dr. Burton Young, DC, FIAMA, Dipl.Ac.

6940 Tylersville Rd, West Chester, OH 45069 • 513-777-9428

So that we may best serve your healthcare needs, please complete the following information as accurately as possible. Thank you!

Confidential Information

Today's Date _____

Legal Name _____ SS# _____ - _____ - _____

Date of Birth _____ Age _____ Gender: Male Female

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Work Phone _____

Cell Phone _____

Email Address _____

This will only be used to send periodic newsletters that discuss conditions chiropractic care can help,
Plus you will receive our website address for general information/updates.

Employer _____ Occupation _____

Whom may we thank for referring you to our office? _____

What sources did you first utilize to choose our office? Check all that apply:

- 1. Yellow Pages ___ 2. Internet ___ 3. Called Insurance ___ 4. Referred ___

Do you have health insurance you wish us to file? Yes ___ No ___

Do you have a secondary insurance through your spouse's employer?

Yes ___ No ___

Marital Status: Single Married Separated Divorced Widowed

Name of Spouse _____ Employer _____

Name of Primary Care Physician and City _____

Authorization for Examination and/or Treatment: fees are payable at the time examination or treatment is received unless prior arrangements have been made. X-rays remain the property of this clinic. I hereby give my permission for treatment.

Signature of Patient (or Guardian if under 18)

Date

Legal Name _____ Date _____

Present Complaint

Please list the primary complain(s) for which you are seeking help:

When did symptoms begin? _____

What caused this condition? _____

If this is due to a Personal Injury or Worker's Compensation, please notify receptionist immediately for additional forms.

Type of pain? Sharp Dull Throbbing Stiff Burning Tingling

Frequency of Pain? Constant Intermittent

What makes the pain better? _____

What makes the pain worse? _____

Have you ever had similar symptoms in the past? Yes _____ No _____

If yes, when and cause (if known)? _____

List other doctors seen for this condition _____

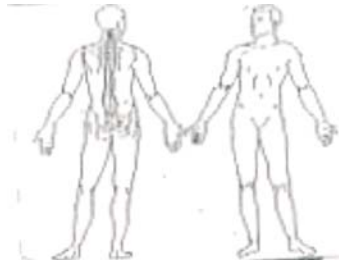
Are you currently taking any medications? Yes _____ No _____

If yes, what kind and what are you taking it for? _____

Have you ever been to a chiropractor Yes _____ No _____

If yes, name of chiropractor and last treatment date _____

Mark areas of pain on figure below:



Put a mark on the scale to indicate your present level of pain

No _____ Worse Possible

Discomfort 1 2 3 4 5 6 7 8 9 10 Discomfort

Health History

List known health conditions (high blood pressure, diabetes, etc.) _____

Previous surgeries (list dates) _____

Are you pregnant? Yes _____ No _____ If so, due date _____

Do you smoke? Yes _____ No _____ If yes, how long? _____

Do you drink alcohol? Yes _____ No _____

Do you exercise regularly? Yes _____ No _____

Have you ever been in an accident? Yes _____ No _____

If yes, briefly describe area injured and date(s) _____

Have you ever been told you had scoliosis? Yes _____ No _____

Patient Name _____ Age _____ Date of Birth _____

Main Complaints 1 _____ 2 _____ 3 _____

Other Concurrent Therapies _____

Past Medical History

General

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Change in appetite (how) _____ | |
| <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Insomnia | <input type="checkbox"/> Trouble falling asleep |
| <input type="checkbox"/> Waking at night | <input type="checkbox"/> Trouble waking | <input type="checkbox"/> Trouble going back to sleep | <input type="checkbox"/> Hours of sleep _____ |
| <input type="checkbox"/> When to bed _____ | <input type="checkbox"/> When to wake _____ | <input type="checkbox"/> Dreams | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Tremors | <input type="checkbox"/> Vertigo | <input type="checkbox"/> Cold hands | <input type="checkbox"/> Cold feet |
| <input type="checkbox"/> Cold back | <input type="checkbox"/> Cold abdomen | <input type="checkbox"/> Fevers | <input type="checkbox"/> Chills |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Sweat easily | <input type="checkbox"/> Cravings | <input type="checkbox"/> Localized weakness |
| <input type="checkbox"/> Poor coordination | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Sudden increase in energy | <input type="checkbox"/> Peculiar tastes or smells |
| <input type="checkbox"/> Strong thirst | <input type="checkbox"/> Bleeding or bruising easily | <input type="checkbox"/> Best time of day _____ | <input type="checkbox"/> Worst time of day _____ |

Skin & Hair

- | | | | |
|---|--|---------------------------------|--------------------------------------|
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Eczema | <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Pimples | <input type="checkbox"/> Purpura | <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Changes in hair/skin texture | <input type="checkbox"/> Other hair or skin problems _____ | | |

Head, Eyes, Ears, Nose & Throat

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions | <input type="checkbox"/> Earaches | <input type="checkbox"/> Ringing in ears |
| <input type="checkbox"/> Poor hearing | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Facial paralysis | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision | <input type="checkbox"/> Blurry vision | <input type="checkbox"/> Night blindness |
| <input type="checkbox"/> Color blindness | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Spots in eyes | <input type="checkbox"/> Nosebleeds |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Mucus | <input type="checkbox"/> Dry throat | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Copious saliva | <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Gum problems | <input type="checkbox"/> Jaw clicks |
| <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> Sores on lips or tongue | <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Other head or neck problems _____ | | |

Cardiovascular

Respiratory

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Production of phlegm | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Tight chest | <input type="checkbox"/> Difficulty when laying down |
| <input type="checkbox"/> Other lung problems _____ | | | |
-

Gastrointestinal

- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Constipation | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Sensitive abdomen | <input type="checkbox"/> Pain or cramps | <input type="checkbox"/> Bloody stools |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Laxative use | <input type="checkbox"/> Undigested food | <input type="checkbox"/> Odor |
-

Genitourinary

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Pain with urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Cloudy urine | <input type="checkbox"/> Urgency to urinate |
| <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Unable to complete | <input type="checkbox"/> Dribbling | <input type="checkbox"/> STD |
| <input type="checkbox"/> Urinary Tract Infection | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Wake to urinate |
-

Gynecology and Pregnancy

- | | | | |
|--|---|---|---------------------------------------|
| Age at first menses _____ | <input type="checkbox"/> Pregnancies # _____ | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Menopause |
| Last PAP _____ | <input type="checkbox"/> Births # _____ | <input type="checkbox"/> Painful periods | <input type="checkbox"/> Clots |
| Last Menses _____ | <input type="checkbox"/> Miscarriages # _____ | <input type="checkbox"/> Vaginal Discharge | <input type="checkbox"/> Breast lumps |
| <input type="checkbox"/> Birth control | <input type="checkbox"/> Premature births | <input type="checkbox"/> Changes in body / psyche prior to menstruation | |
-

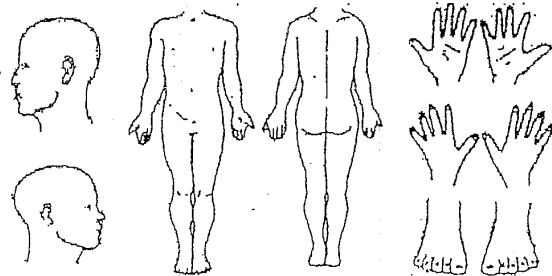
Neuropsychological

- | | | | |
|---|--|---|--|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Areas of numbness | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Concussion |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Bad temper | <input type="checkbox"/> Easily stressed |
| <input type="checkbox"/> Treated for emotional problems | | <input type="checkbox"/> Considered / attempted suicide | |
| <input type="checkbox"/> Other neurological or psychological problems _____ | | | |
-

Musculoskeletal

- | | |
|---|---|
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Better / worse with heat |
| <input type="checkbox"/> Limb pain | <input type="checkbox"/> Better / worse with cold |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Better / worse with movement |
| <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Better / worse with pressure |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Fixed location |
| <input type="checkbox"/> Sharp quality | <input type="checkbox"/> Dull quality |
| <input type="checkbox"/> Distending quality | <input type="checkbox"/> Radiating quality |
| <input type="checkbox"/> Burning quality | <input type="checkbox"/> Stabbing quality |

Mark Location of Pain or injury



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WORKER’S COMPENSATION HISTORY

Name _____ Age _____ Date of Birth _____ Male Female

Address _____ City _____ State _____ Zip _____

SS# _____ Drivers Lic # _____

Employers Name _____ Tel # _____

Address _____ City _____ State _____ Zip _____

Carriers Name _____ Tel # _____

Address _____ City _____ State _____ Zip _____

Have your retained legal counsel for this injury? Yes No If yes, give name and address _____

INJURY DESCRIPTION

Date present injury was received _____ Time of in jury _____ AM PM Overtime: Yes No

Who saw the accident: Name _____ Title _____

Who reported the accident? Name _____ Title _____

What medical attention was rendered? _____

By whom? Nurse M.D. D.O. D.C Other employee Other _____

How did the injury occur? _____

Chief complaint _____

Symptoms _____

Since the injury, are your symptoms: Improving The same Getting worse

If working on a machine, give description _____

Do you use foot or hand levers? Yes No Do you work overhead? Yes No

Do you have to reach? Yes No Where? _____

Movements on the job: Do you move to your Right Left Up Down Under Over

Do you pick up or lift? Yes No If yes, how much? _____ How often? _____

From where to where? _____ Do you lift from Ground Bench Platform

Box Pallet Other (Please Describe) _____

Do you lift in or out of a machine? Yes No If working at a machine, do you Sit Stand Kneel

Is your work area cluttered? Yes No If yes, with what? _____

Is your work area Oily Dirty Slippery Other _____

In your job do you push or pull? Yes No If yes, give specifics _____

Do you use a cart? Yes No Two-wheel Four-wheel Type of wheels: Rubber Steel Plastic

Condition of cart Good Bad Other _____ Number of carts being pushed or pulled at once _____

Total amount of weight being pushed or pulled on a daily basis _____

OFFICE WORK

If your injury has occurred from office work only, please fill out the following:

Sit at desk Walk Stand Stoop Hold Carry Other _____

Give percentage if applicable _____ Do you operate office machinery? Yes No

If yes, what type? _____

If your work is at a desk, give specifics of job, computer, typewriter, business machines, phone, etc.

If walking, where to and job classification _____

Do you carry anything or pick anything up? Yes No If yes, what? _____

PREVIOUS WORK HISTORY

Give a job description of services or work performed for each job classification or source of employment for the preceding ten (10) years.

1. _____
2. _____
3. _____
4. _____
5. _____

Was a pre-employment exam performed or required? Yes No

Date _____ Doctor _____ Place _____

Have you ever applied for Workers' Compensation benefits before? Yes No Date _____

Reason _____

Was there a time loss from work? Yes No From _____ To _____ Year _____

State the degree of recovery _____

Did you retain legal counsel for these injuries? Yes No If yes, give name and address _____

PRESENT WORK HISTORY

What is the job classification of your normal job? _____

Were you performing your normal job? Yes No What shift were you working? _____

How long have you been at your present job? _____ Has there been a time loss or absenteeism caused from job injury? Yes No If yes, explain _____

Average work week _____ Hours _____ Days _____

JOB CONDITIONS

Type of building _____

Type of floor Rough Smooth Wood Concrete Steel Other _____

Type of windows Open Closed No windows

Type of ventilation in the building Blower A/C Heat Exhaust None Other _____

Type of lighting in the building Fluorescent Overhead On machine Other _____

Are you tired when you go home at night? Yes No

Do you have any outside jobs? Yes No If yes, what type? _____

Do you participate in any company-sponsored programs such as exercise, sports, etc.? Yes No

If yes, describe _____

Type of shop Union Non-union

Has outside help been hired? Yes No If yes, why? _____

How many employees are in the plant? _____ How many employees per shift? _____

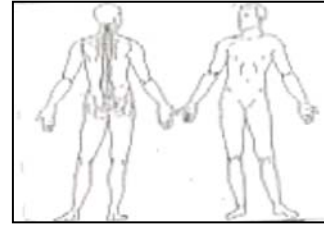
How many employees do your job? _____ What is the current injury ratio for that job? _____

How many employees have been injured doing your job? _____ Do you like your job? Yes No

If off work, do you want to return to your job? Yes No

What changes would you make in your job? _____

<u>MARK PAIN AREA</u>	
+++	BURNING
000	STABBING
---	SHARP
///	CONSTANT



Patient Signature

Date

Staff Signature

Date

[* Click here to download First Report of Injury Form from Bureau of Workers Compensation website \(scroll to bottom of page and click "Complete FROI"\).](#)

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PRACTICE'S REQUIREMENTS

The Practice:

- (a) Is required by federal law to maintain the privacy of your Personal Health Information (PHI) and to provide you with a Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI unless a copy has not been requested as acknowledged below by the patient's signature.
- (b) Under the Privacy Rule, may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.
- (c) Is required to abide by the terms of this Privacy Notice.
- (d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.
- (e) Will distribute any revised Privacy Notice to you prior to implementation.
- (f) Will not retaliate against you for filing a complaint.

This notice is effective as of April 15, 2003.

PATIENT ACKNOWLEDGEMENT

(Choose one)

- By subscribing my name below, I acknowledge my understanding and agreement to these terms. I do not want a copy of my HIPPA laws at this time.
- By subscribing my name below, I acknowledge receipt of a copy of the above-mentioned notice and my understanding and agreement to its terms. I have requested a copy of my HIPPA laws at this time.

Signature of Patient (or Guardian if under 18 years)

Date

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FINANCIAL POLICY

Please put a check by the form of payment you will be using

CASH

Patient pays all fees on the day services are rendered by cash, check, or credit card. We accept Visa, Mastercard, Discover and American Express.

INSURANCE

You are ultimately responsible for knowing what your insurance plan covers. As a courtesy, we will verify your insurance coverage, however this does not guarantee benefits. If you would like a copy of what we verify, please notify the receptionist. YOU are responsible for the portion your policy not covered such as deductibles, co-payments and non-covered services. Payment is due on the date services are rendered.

WORKER'S COMPENSATION

It is your responsibility to notify your employer and the doctor if you are seeking treatment from an injury sustained while on-the-job. This type of injury is classified as an industrial injury and will be billed accordingly. If the injury neglects to meet the requirements of the Industrial Commission and they will not pay, you are responsible for all charges incurred in this office. If you have an established claim, please notify the receptionist that you need to sign a transfer of physician form.

PERSONAL INJURY

We do not accept third-party payer. We do not bill the at-fault. If Dr. Hilbert/Dr. Young (dba West Chester Acupuncture and Chiropractic) are a preferred provider on your health insurance plan, then by Ohio State Law we are required to bill your health insurance first. Standard rules apply when billing your health insurance: any co-payments, co-insurance, deductibles or non-covered services are your responsibility to pay at the time services are rendered. Once the health insurance coverage has been exhausted for the benefit year, we will then collect full payment for services rendered. A copy of charges will be provided for you to be reimbursed by either your automobile insurance, which has med pay coverage for health care from injuries sustained in a motor vehicle accident or the at-fault party insurance. We recommend that you immediately file a claim with your automobile insurance. If you do not have health insurance or med pay, then you are responsible to pay as treatment is received on the day of each visit by cash, check or credit card. Financing is available – ask our front desk if you are interested. Each case is unique so please do not hesitate to ask the receptionist. Ultimately, you are responsible for all charges incurred for treatment in our office.

MEDICARE

Medicare does cover chiropractic treatment but with limitations. We have a handout specifically for Medicare patients, including those with secondary insurance that will explain in detail what you can expect with your current coverage. Please let the receptionist know if you would like a copy.

MEDICAID

If eligible, you must bring a current Medicaid card on the first visit and at the beginning of each month thereafter when receiving treatment.

I hereby authorize any holder of medical information to release to my insurance company or intermediates any information needed to process a claim for payment. I request that payment be made to West Chester Acupuncture and Chiropractic for any charges or services rendered to me by Julie B Hilbert, DC, FIAMA, Dipl.Ac. and/or Burton T Young, DC, FIAMA, Dipl.Ac.. I understand I am financially responsible to Julie B Hilbert DC, FIAMA, Dipl.Ac. and/or Burton T Young DC, FIAMA, Dipl.Ac. for any balance not covered. I agree to the terms in the financial policy as stated above for the acupuncture and/or chiropractic care rendered to me by Julie B Hilbert DC, FIAMA, Dipl.Ac. and/or Burton T Young DC, FIAMA, Dipl.Ac.. Balances over 90 days past due will be forwarded to our collections agency. A late fee of 1.5% per month will be added to the balance, beginning at 60 days after service is rendered.

Signature of Patient (Parent/Guardian)

Date

Witness

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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 hereby authorize the Doctors and/or Staff to discuss my medical information with the person(s) listed below.

Allowed person(s):

Relation

We occasionally call your home regarding your appointment for two reasons. If you miss your appointment we are calling to reschedule and/or we would be calling to remind you of a massage appointment if applicable for the next day.

_____ I give my permission to call my home or cell for the above reasons.

_____ I do not give my permission to call my home or cell for the above reasons.

****Permission to leave messages on voice mail/answering machine?**

(Please circle)

Yes

No

Patient Name: _____ Patient DOB: _____
(Please print)

Signature: _____ Date: _____
(Patient/Guardian of minor/Legal Representative)