Dr. Meghan's
HEALING HANDS
CHIROPRACTIC

Meghan Curiale, D.C.
267 Pittsburgh Road | Butler, PA 16002
Phone: 724-256-9828 | Fax: 724256-9827

WELCOME TO OUR OFFICE!

Please fill in all information and PRINT CLEARLY

Name _____ Preferred/Nickname _____ Sex: ☐ M ☐ F

Address _____ City _____ State _____ Zip _____

Home phone _____ Cell phone _____ E-mail _____

Social Security # _____ - _____ - _____ Birth date _____ / _____ / _____ Age _____

Employer _____ Occupation _____ Work phone _____

Work address _____ City _____ State _____ Zip _____

Is it okay to contact you at work? ☐ Yes ☐ No

Status: ☐ Minor ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Spouse's Name_____ Phone # (s) _____

Children's names and ages: _____

Emergency contact: Name _____ Relationship _____ Phone_____

How did you hear about us?

☐ Referral (who?) _____ ☐ Newspaper/Ad ☐ Insurance Directory
☐ Spinal Screening (where?) _____ ☐ Telemarketing Call ☐ Yellow Pages
☐ Saw Sign (knew location) ☐ Internet ☐ Other _____

What brings you here?

Have you ever had chiropractic care before? ☐ Yes ☐ No

What is the reason for this appointment? _____

Is this appointment related to: ☐ Work ☐ Auto ☐ Sports ☐ Not Applicable

Date problem began: _____ Is it getting worse? ☐ Yes ☐ No Is it constant? (✓) ___ Or come and go? (✓) ___

Have you had a similar condition in the past? ☐ Yes ☐ No When? _____

What have you done for this problem? _____

Have you had spinal X-Rays/MRI/CT Scan? ☐ Yes ☐ No Date(s) taken:_____

Health History

What other health problems do you have? _____

_____

Please list any drugs or medications you are taking: _____

_____

Please list any vitamins/herbs/homeopathics you are taking: _____

_____

_____

Health History Continued

Have you had any surgeries? Please list:_____

_____

Are you pregnant? ☐ Yes ☐ No If yes, What month? _____

Have you ever been in a work or auto accident? ☐ Yes ☐ No When? _____

Do you smoke? ☐ Yes ☐ No How much? _____ Do you drink alcohol? ☐ Yes ☐ No How much? _____

Do you use illegal drugs? ☐ Yes ☐ No How much?_____ Do you know what an Advanced Directive is? ⬇ **See box below**

Advance Directives are a means for you to tell your health care givers about the care you wish to receive, or not receive, should you ever become unable to tell them of your wishes. There are two forms of advance directives. The first is a Living Will. The other is known as a "Durable Power of Attorney for Health Care Decisions", or may also be called "Durable Appointment of a Surrogate Health Care Decision". Please discuss your Advance Directive choices with your Primary Care Physician.

Have you been diagnosed with cancer? ☐ Yes ☐ No Year:_____ Type:_____

Family History: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Cardiovascular Problems/Stroke

Your Medical Doctor's Name _____ Date of last physical exam: _____

Address _____ City _____ Zip _____ Phone Number _____

If you have not done so already, please give the receptionist your Health Insurance Card and Driver's License or Photo ID, so it can be copied. Thank You.

Insurance / Financial Responsibility

Who is responsible for payment? _____

Insured's Name _____ Relationship to Insured: ☐Self ☐Spouse ☐Child ☐Other

Insured's birth date **if other than self:** _____ / _____/ _____

Primary Insurance Company _____ ID# _____ Group # _____

Secondary Insurance Company _____ ID# _____ Group # _____

Notice of Privacy Practices**:** Healing Hands Chiropractic is required, by law, to maintain the privacy and confidentiality of your protected health information. You have the right to a paper copy of this Notice of Privacy Practices at any time upon request. By way of my signature, I provide Newman Chiropractic Center with my authorization and consent to use and disclose my protected health care information for the purposes of treatment, payment and health care operations as described in the Privacy Notice.

Patient Name (PRINT) _____

Patient Signature _____ Date _____

Any x-rays taken at this office will remain the property of this office. I authorize Dr. Meghans Healing Hands Chiropractic to release information to my insurance company for payment. I authorize release of information to Dr. Meghans Healing Hands Chiropractic from other facilities regarding treatment. The above statements are true to the best of my knowledge.

Patient Signature _____ Date _____

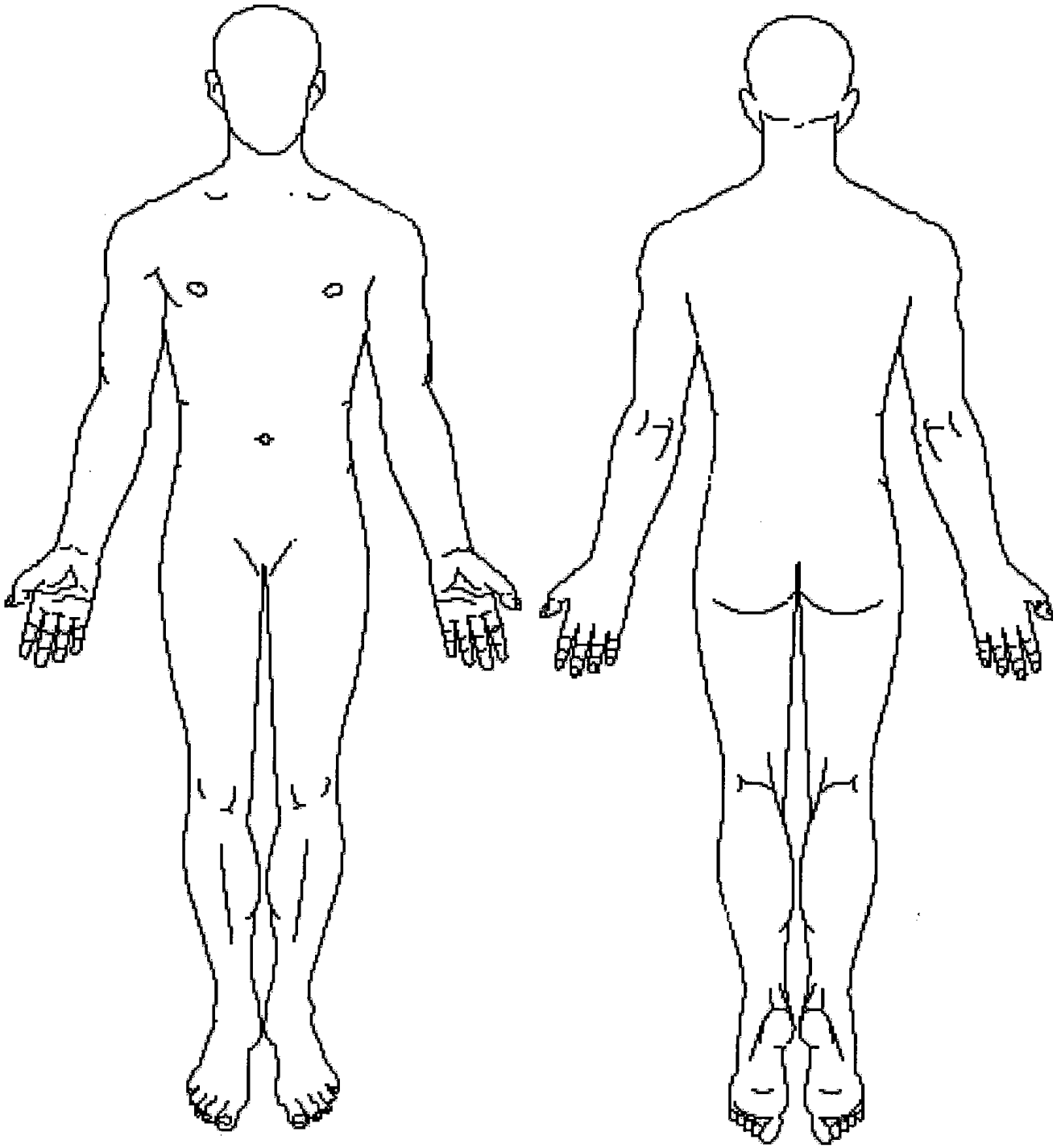
PAIN DRAWING

Patient Name: _____ Date: _____

Attending Dr: Meghan Curiale, D.C.

Using the letters below, mark the areas on your body where you feel the described sensations. Include all affected areas. Please complete the picture by drawing your face.

A = Ache **B** = Burning **N** = Numbness **P** = Pins and Needles **S** = Stabbing



Patient Signature: _____

Date: _____