East Penn Chiropractic & Healing Arts Center
Dr. Robin Kaplan, DC, DACRB, CCEP, CES
9620 Hamilton Blvd. Suite A, Breinigsville, PA 18031
Phone: 610-395-2400

CONFIDENTIAL PATIENT HEALTH HISTORY FOR MINORS

Patient Name _____ D.O.B._____ ☐ M ☐ F
Address_____ City_____ State _____
Zip_____ SS#_____ Home phone #_____
Parent and/or Legal Guardian Name or Names _____
Address_____ City_____ State_____
Zip_____ SS#_____ Home phone #_____
Cell phone #_____
Insurance Co._____ ID#_____ Group#_____
Insured's Name_____ Insured's SS#_____
Insured's Date of Birth _____
Insured's Employer _____ Emergency Contact Name_____
Emergency Contact #_____ Relationship to patient _____
Name of Pediatrician_____ Office Phone #_____

CURRENT HEALTH CONDITIONS & STAGES OF DEVELOPMENT

Has your child ever had difficulty with or suffered from:

	yes	no	unsure	N/A – too young
1. Breastfeeding				
2. Raising Head				
3. Crawling				
4. Walking				
5. Colic				
6. Bed Wetting				
7. Ear infections				
8. Respiratory Illnesses				
9. Balance/ Coordination				

PAST MEDICAL HISTORY

Name of hospital or birthplace of child_____
Location of hospital where child was born_____
Type of delivery: vaginal or c-section
Were there any complications?_____
Has your child been vaccinated? Y or N. If so, did your child show any symptoms after his/her vaccinations?_____

Parent/Guardian Signature _____ **Date**_____

East Penn Chiropractic & Healing Arts Center

Patient Questionnaire

Patient Name_____ Date of Birth_____

PLEASE READ CAREFULLY

Please check the appropriate response. If you are not sure, check the "?".

NO	**YES**	**?**
( )	( )	( ) Do you have a past history of cancer?
( )	( )	( ) Have you had any unexplained weight loss?
( )	( )	( ) Does your pain fail to improve with rest?
( )	( )	( ) Are you over 50 years old?
( )	( )	( ) Failure to respond to a course of conservative care (4-6 wks)
( )	( )	( ) Have you had spinal pain greater than 4 weeks?
( )	( )	( ) Prolonged use of corticosteroids (such as organ transplant RX)
( )	( )	( ) Intravenous drug use?
( )	( )	( ) Current or recent urinary tract, respiratory tract, or any other type of infection?
( )	( )	( ) Immunosuppression medications and/or condition?
( )	( )	( ) History of significant trauma?
( )	( )	( ) History of minor trauma?
( )	( )	( ) Do you have osteopenia or osteoporosis?
( )	( )	( ) Have you had any fractures (broken bones)?
( )	( )	( ) Sudden onset of urinary retention or overflow incontinence?
( )	( )	( ) Loss of anal sphincter tone or fecal incontinence?
( )	( )	( ) Saddle paresthesia (numbness in the groin area)?
( )	( )	( ) Global or progressive muscle weakness in legs (legs give out)?

Comments or additional information for the Doctor:

Signature_____ Date_____

QUADRUPLE VISUAL ANALOGUE SCALE

Patient Name: _____ Date: _____

Instructions: Please circle the number that best describes the question being asked.

Note: If you have more than one complaint, please answer each question for each individual complaint and indicate the score for each complaint. Please indicate your pain level right now, average pain, and pain at its best and worst.

Example:

Headache Neck Low Back

No pain **worst possible pain**

0 1 (2) 3 4 (5) 6 7 (8) 9 10

---

1 – What is your pain RIGHT NOW?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

2 – What is your TYPICAL or AVERAGE pain?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

3 – What is your pain level AT ITS BEST (How close to "0" does your pain get at its best)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

4 – What is your pain level AT ITS WORST (How close to "10" does your pain get at its worst)?

No pain **worst possible pain**

0 1 2 3 4 5 6 7 8 9 10

OTHER COMMENTS:

_____

_____

_____

_____ _____

Patient's Signature Examiner's Signature

DIFFICULTY IN PERFORMING ACTIVITIES OF DAILY LIVING

PATIENT NAME: _____

Check each of the activities which you have difficulty performing and/or can perform only with pain. (There is no particular priority in the order presented.)

HOUSEWORK

____ Doing Laundry
____ Making Beds
____ Vacuuming
____ Washing Dishes
____ Ironing
____ Carrying Groceries
____ Caring for Pets
____ Cooking
____ Other _____

YARDWORK

____ Mowing Lawn
____ Shoveling Snow
____ Raking Leaves
____ Gardening

GENERAL

____ Walking
____ Standing
____ Running
____ Sitting
____ Lifting Children
____ Bending
____ Climbing Stairs
____ Reading
____ Lying in Bed
____ Swimming
____ Sports:_____

PERSONAL GROOMING

____ Combing Hair
____ Shaving
____ In/Out Bathtub
____ Brushing Teeth
____ Other_____

TRAVEL

____ Driving
____ Riding (Passenger)

Minutes of Travel per Day

Type of Vehicle

Auto _____
Train _____
Bus _____
Truck _____
Airplane _____

____ Getting in and out of Auto
____ Playing Piano
____ Using Typewriter/Computer
____ Kneeling
____ Sexual Intercourse
____ Exercising
____ Sleeping
____ Using Telephone
____ Sitting in Recliner
____ Chewing

OTHER: Please list any other difficulties you are experiencing with activities you have engaged in since your condition arose:

_____

Patient Signature _____ Date _____

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CONSENT TO TREATMENT OF A MINOR

Minor's Name: _____

****

I, the undersigned, attest that I am the custodial parent or legal guardian of the above-referenced minor ("the minor"), and hereby authorize East Penn Chiropractic to administer treatment as it so deems necessary to the minor. In the event that the minor has received treatment at your practice previous to the date of this consent form, I hereby authorize such treatment in addition to the treatment mentioned above. I further authorize the minor to complete and sign any documents at East Penn Chiropractic which are customarily completed and signed by patients at your practice as a condition to treatment, and such signature shall serve as my own. In no event shall my signature to any other such document have any effect on this consent form.

Name of Custodial Parent/Legal Guardian (please spell clearly): _____

Relationship to the minor:

☐ Custodial Parent ☐ Adoptive parent with custody

☐ Guardian by Law. Date Guardianship Commenced: ___/___/___

☐ Other (please specify): _____

Social Security # of Parent/Guardian: _____ Date of Birth: __/__/__

Address of Parent/Guardian: _____

_____

Home Phone #: (____) _____ Work Phone #: (____) _____

Signature: _____ Date: ___/___/___

Witness (if any)

Witness' Name: _____

Witness' signature: _____ Date: ___/___/___

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Informed Consent

The following examination is comprised of a series of tests designed to measure your strength and/or functional abilities that relate to performing daily activities. Some of the components of the exam will look specifically at your body's ability to provide muscle resistance and your ability to move your extremities and spine. This information will assist in defining and determining the degree of impact your injury is having on your ability to perform daily tasks.

Your participation in this exam requests of you to exert maximal motion, force and effort in response to the activities offered to you to the best of your ability without changing your current level of being. Because you are going to be asked to engage in physical activity, you must be aware that there is the potential for injury or aggravation to your current status. Make sure that you understand all that is asked of you, that you understand fully the instructions and to stop or not engage in any offered activity that you are not comfortable with. If at any point in time you have increase in pain, stop the activity that you are engaging in and report the increased pain. Do not perform any activity that you feel you are unable to perform. At no point in time will you be encouraged to participate in this exam beyond the levels that you feel comfortable with. If you do engage in a given activity, you can terminate your participation at any point in time. Remember, the goal of this exam is to determine your best ability without changing your current level of being. There is no goal that focuses on what you can do despite a worsening of your condition.

You may be placed in positions to isolate and test specific areas of your body. You may be asked to perform isometric tests, simulated lift tasks, cardiovascular tests, work activities, work postures, individual muscle tests, hand strength tests, and/or range of motion tests. You will be asked to give your best effort without causing yourself any pain. You may be asked to repeat these procedures 2 to 4 times to determine your best effort. You will be allowed to rest at least thirty (30) seconds between each repetition.

You will be exposed to certain risks when performing the aforementioned tests, including temporary pain, a worsening of any existing injury, or a new injury. It is not possible to determine in advance whether or to what extent you will experience any of these complications as a result of doing these tests.

It is your responsibility to inform your evaluator if you have any physical limitations or restrictions prior to beginning the tests. You should gradually exert force or movement until you have reached maximum effort without experiencing any pain. You should not jerk or use any form of ballistic movement. If you feel any pain, you must stop the test, and immediately report to the evaluator what has happened.

I understand the above procedures, risks, and instructions and agree to participate in the examination to the best of my ability.

Patient Signature_____

Date

Clinician/Examiner_____

Date

East Penn Chiropractic & Healing Arts Center

INSURANCE AUTHORIZATION FORM

NON-MEDICARE PATIENTS PLEASE FILL OUT THE FOLLOWING INFORMATION:

PATIENT NAME_____

☐ WORKER'S COMPENSATION ☐ AUTO ☐ COMMERCIAL (PERSONAL)

Name of Insurance Company_____

Authorization to Release Medical Information- "I authorize East Penn Chiropractic to release any information required to complete my worker's compensation, auto and/or insurance claim to my employer/insurance company pertaining to my chiropractic treatment and spinal rehabilitation."

Signature_____ Date_____

Assignment of Insurance Benefits "I hereby assign to East Penn Chiropractic & Healing Arts Center and authorize and direct that payment be made directly to East Penn Chiropractic, of all benefits otherwise payable to me directly under the terms of my insurance policies (including major medical) by reason of the services described in the statements rendered by EPC; provided that EPC shall refund to the person or persons entitled to receive the same, any payments in excess of its full charges. I understand that I am financially responsible for all charges not recovered by this assignment"

Signature_____ Date_____

FOR MEDICARE PATIENTS ONLY:

PATIENT NAME_____

Statement to Permit Payment of Medicare Benefits to Provider, Physician's and Patient
I request payment of authorized Medicare Benefits to me or in my behalf for any services furnished to me by East Penn Chiropractic. I authorize any holder of medical and other information about me to release to the Health Care Financing Administration (Medicare) and its agents, any information needed to determine benefits or benefits for related services. I understand that I am responsible for any health insurance deductibles, co-insurance or other non-covered services.

Date_____ Signature-Beneficiary_____

Date_____ Other Signature/Relationship_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY AND FINANCIAL PRACTICES

By signing below I acknowledge that a copy of East Penn Chiropractic & Healing Arts Center Notice of Privacy and Financial Practices are available to me.

_____ _____

Signature of patient or personal representative Date

_____

If signed by a personal representative, state relationship to patient

_____

***Office Use Only*:**

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient name: _____

Refused to sign ☐ Physically unable to sign ☐

(Other)

_____

_____

_____

Employee Signature: _____ Date: _____

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Cancellation and No Show Policy

We understand that situations arise in which you must cancel your appointment. Please understand that when you forget or cancel your appointment without giving enough notice, we miss the opportunity to fill that appointment, and patients on our waiting list miss the opportunity to receive services. As a courtesy, we call to remind you of your appointment. However, if we are unable to reach you, and can only leave a message, please understand that it is your responsibility to remember your appointment dates and times.

Each patient will be allowed 1 short notice (less than 24 hours) or a no show appointment per calendar year. Consequently, a 2nd occurrence will result in a fee of $30.00 for the time reserved. If this amount is not paid in full, you will not be permitted to schedule future appointments.

We thank you for your cooperation.

I have read and understand the appointment cancellation policy of East Penn Chiropractic and agree to be bound by its terms.

_____ _____

Please print name Signature and date

EAST PENN CHIROPRACTIC AND HEALING ARTS
Dr. Robin Kaplan
9620 Hamilton Blvd. Suite A, Breinigsville, PA 18031
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Name_____ Phone_____

From time to time it may be necessary to contact you in regards to test results, appointment reminders, information, etc. In order to eliminate delays in providing you with this information, please choose the manner you wish to use in the event we are unable to contact you personally.

YES ( ) NO ( ) 1. May messages be left on your home answering machine?
Provide home number_____

YES ( ) NO ( ) 2. May we call you or leave a message at your work number?
Provide work number_____

YES ( ) NO ( ) 3. May we call you or leave a message on your cell phone?
Provide cell number_____

YES ( ) NO ( ) 4. May we text you a reminder to your cell phone?
Provide cell number_____

YES ( ) NO ( ) 5. May we e-mail you a reminder?
Provide e-mail address_____

YES ( ) NO ( ) 6. May we leave information with family members?
Provide names and relationship to you:

_____

_____

Person to call in case of emergency_____

Relationship to you_____

Phone number_____

Signature_____ Date_____