

**A-100 PERCENT HEALTH**  
**FEINBERG CHIROPRACTIC**  
**Ronald D. Feinberg, DC, RCRD**

Licensed PA Chiropractor and FL Chiropractic Physician  
Postgraduate Studies: Radiology, Exercise, Physiology, & Nutrition

Recognized Chiropractic Rehabilitation Doctor  
Certified in Chiropractic Pediatrics (children)

Name \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

H. Phone \_\_\_\_\_ W. Phone \_\_\_\_\_ Cell phone \_\_\_\_\_

D.O.B. \_\_\_\_\_ Social Security # \_\_\_\_\_ Email \_\_\_\_\_

Marital Status:  Single  Married  Divorced  Widowed Spouse's Name: \_\_\_\_\_

Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Previous Chiropractor \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Referred By:  Family  Friend  Insurance  Yellow Pages  Other \_\_\_\_\_

**About Your Health**

The human body is designed to be healthy. Throughout life, events occur which damage your health. This history form will help identify current and past health issues and injuries that can contribute to poor health. After your exam, Dr. Feinberg will outline a course of care to begin correcting injuries and improving your health.

**Current Complaint: (Why are you here today?)**

**Is it affecting:**  Work  Home life  Sleep  Exercise  Hobbies/having fun  Other \_\_\_\_\_

**If you have pain, what type?**  Sharp  Dull  Burning  Aching  Other \_\_\_\_\_

**When do you have pain?**  Constantly  Most days  Only sometimes

**When is your pain worse?**  Morning  Evening  When trying to sleep

**What makes your pain worse?**  Sitting  Standing  Lying down  Exercise  Other \_\_\_\_\_

**How long have you had this problem?** \_\_\_\_\_

**It is:**  Getting better  Staying about the same  Getting worse

**What have you tried to make the problem better/get some relief?** \_\_\_\_\_

**Do you have any of the following?**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Problem falling/staying asleep | <input type="checkbox"/> Anxiety/worrying           | <input type="checkbox"/> Headaches               |
| <input type="checkbox"/> Tiredness/fatigue              | <input type="checkbox"/> Depression/sadness         | <input type="checkbox"/> Ringing in ears         |
| <input type="checkbox"/> Lack of energy                 | <input type="checkbox"/> Irritability               | <input type="checkbox"/> Sinus problems          |
| <input type="checkbox"/> Diarrhea/loose bowels          | <input type="checkbox"/> Dizziness/balance problems | <input type="checkbox"/> Allergies               |
| <input type="checkbox"/> Constipation                   | <input type="checkbox"/> Chest pain                 | <input type="checkbox"/> Breathing problems      |
| <br>  |   |  |
| <input type="checkbox"/> Arthritis                      | <input type="checkbox"/> Diabetes                   | <input type="checkbox"/> Liver problems          |
| <input type="checkbox"/> Asthma                         | <input type="checkbox"/> Epilepsy/seizures          | <input type="checkbox"/> Lung condition          |
| <input type="checkbox"/> Autoimmune disease             | <input type="checkbox"/> High blood pressure        | <input type="checkbox"/> Menstrual problems/pain |
| <input type="checkbox"/> Bladder problems               | <input type="checkbox"/> Heart problems             | <input type="checkbox"/> Neurological problems   |
| <input type="checkbox"/> Bowel problems/disease         | <input type="checkbox"/> Kidney problems            | <input type="checkbox"/> Stomach problems/reflux |

**Do you spend a lot of time doing the following?**  Sitting  Standing  Desk/computer work  
 Heavy or frequent lifting  Doing the same physical task over and over again (repetitive motion)

**For each part of the body, check any symptoms you experience:**

Head	Pain	Numbness	Sensitivity to Cold	Swelling	Stiffness/Limited Movement
Neck					
Shoulder					
Arm					
Hand/Finger					
Back					
Hip					
Leg/Knee					
Foot/Toe					

**Have you had any accidents, physical traumas, major illnesses, or surgeries? If yes, list them below:**

Year	Accident, Trauma, Illness, or Surgery

**How would you describe your current stress level?**  Low  Medium  High  Extremely high

**Diet & Exercise**

A healthy diet and regular exercise can help manage pain, assist the body in healing, and improve overall quality of life. Dr. Feinberg can talk with you about how to improve your diet and develop an exercise program that makes sense for you, given your health, lifestyle, and preferences.

**Do you ...?**

- |   |  |
|---|--|
| <input type="checkbox"/> Drink more than 2 drinks with caffeine/day | <input type="checkbox"/> Smoke (_____ packs/day)             |
| <input type="checkbox"/> Drink alcohol                              | <input type="checkbox"/> Want to improve your diet/nutrition |

**Medications, drugs, & vitamins/supplements you take:** \_\_\_\_\_

**INSURANCE INFORMATION** – Please present card(s) or complete the following:

Name of insured \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured's D.O.B. \_\_\_\_\_ Insured's SS # \_\_\_\_\_

Group Name/Number \_\_\_\_\_ ID # \_\_\_\_\_

Insured's Employer Name & Address \_\_\_\_\_

**PAYMENT AGREEMENT**

I understand that health and accident insurance policies are an arrangement between my insurance company and me and NOT between the insurance company and Dr. Feinberg/Feinberg Chiropractic. I request Feinberg Chiropractic to complete any usual and customary reports and forms to assist in the collection of funds from my insurance company.

I understand that I am ultimately responsible for payment in full at this office. If there is a contractual agreement between my insurance company and me that requiring that I pay a deductible before a percentage of the doctor's services are paid, I will pay those deductibles, as determined by the insurance company, directly to the doctor.

If my plan requires a co-pay, I agree to pay for services unless other written arrangements have been made.

I know that Dr. Feinberg will talk with me about possible alternate payment plans in the event that financial hardship threatens to disrupt my treatment plan.

I understand that if I suspend or terminate my schedule of care, as determined by the doctor, any fees for professional services will be due immediately. Any outstanding balance over 30 days will incur a \$10.00 late fee.

If my case is a personal injury case, I will complete and immediately submit an Application of Benefits form supplied by my insurance company.

I request that payment of authorized insurance benefits be made on my behalf to Dr. Ronald Feinberg for any service furnished to me by him or his staff at A-100 Percent Health/Feinberg Chiropractic.

I understand my HIPAA rights and know that I may request a copy of those rights. If I am a Medicare client, I understand the Medicare Advanced Beneficiary Notice as it relates to services not covered by Medicare.

\_\_\_\_\_  
Patient's signature Date

\_\_\_\_\_  
Guardian's signature if patient a minor Date

**X-RAY SERVICES:** I understand that there are Network Radiographic Facilities for my insurance, but I agree to obtain X-ray services from Dr. Feinberg due to the nature of my injury(ies) or for reasons of expediency.

\_\_\_\_\_  
Patient's signature Date

\_\_\_\_\_  
Guardian's signature if patient a minor Date

## INFORMED CONSENT FOR CHIROPRACTIC CARE

When a patient seeks chiropractic health care and Dr. Feinberg accepts a patient for such care, it is essential for both to be working for the same objective. It is important that each patient understand both the objective and the method that will be used to attain it. This will prevent any confusion or disappointment. As a patient, you have the right to be informed about the condition of your health, the recommended care and treatment to be provided, and the known benefits, risks, and alternatives before making a decision about whether or not to undergo the recommended chiropractic care.

Chiropractic is a science and art which concerns itself with the relationship between structure (primarily, the spine) and function (primarily, the nervous system) as that relationship may effect the restoration and preservation of health. Health is a state of optimal physical, mental, and social wellbeing, 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 alteration of 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 adjustment. An adjustment is the specific application of forces to correct and/or reduce vertebral subluxation. Dr. Feinberg's primary method of correction is by making specific adjustments of the spine. Adjustments are usually done by hand, but may be performed by handheld instruments. Physiotherapy and/or rehabilitative procedures may be also be used during treatment.

If non-chiropractic or unusual health findings are discovered during the course of care, Dr. Feinberg will advise you of those findings and recommend that you seek the services of another healthcare provider.

---

***All questions regarding the doctor's objective pertaining to my care in this office have 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.***

---

Patient's Printed Name

---

Signature

---

Date

***I am the parent or legal guardian of the child named above. I have read and fully understand this Informed Consent and hereby grant permission for the child to receive chiropractic care.***

---

Guardian's Printed Name

---

Signature

---

Date

### Pregnancy Release

***I have been advised that x-rays can be hazardous to an unborn child. This is to certify that, to the best of my knowledge, I am not pregnant. Dr. Feinberg/his associates have my permission to perform an x-ray evaluation.***

---

Signature

---

Date