Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino
237 Leatherman Rd Wadsworth Ohio
Phone: (330) 336-2120 ~ Fax: (330) 334-8305 Date:_____

Confidential Patient Information

Patient's Name: _____ Work Status: Part Time Full Time Not employed

Address: _____ Occupation: _____

City/State: _____ Zip:_____ Employer: _____

Home Phone: _____ Cell Phone: _____ Are you limited in work capacity? _____

Text Reminders: Y___ N___ Cell Carrier: _____ Driver's License Number: _____

Email Address: _____ Chief Complaint: _____

Birth Date: _____ Age: _____ Sex: M F Relationship of Insured: Self Spouse Child Other

Marital Status: Married Single Widowed Divorced

SS#: _____

Referred by: Family Friend Doctor Internet Event Phone Book _____

Are your present systems or condition related to, or the result of an auto collision, work-related injury or other personal injury? (Someone else might be responsible for payment?) Yes ____ No ____

Ins. Company: _____ Ins. Phone #: _____

ID#: _____ Group #: _____

Name and Address of Insured (if different): _____

Policy Holder DOB: _____Policy Holders Employer: _____

Secondary Insurance Company:_____ #:_____

Family Physician: _____ (Note: May we send your health information to this provider (Y / N)

Person to contact in case of emergency (Name and Phone): _____

What is your goal in our office? _____

I have read and understand THE NOTICE OF PRIVACY PRACTICES, PATIENT RIGHT AND RESPONSIBILITES POLICY, PATIENT RESPONSIBILITIES AND GRIEVANCE POLICY AND PROCEDURES FOR PATIENT. I understand the necessity of these policies and all my questions have been answered in regard to these policies. By signing this form, you give Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino and staff permission to contact you by either phone, mail or email.

Signature_____Date:_____

LEGAL ASSIGNMENT OF BENEFITS AND RELEASE OF MEDICAL AND PLAN DOCUMENTS

In considering the amount of medical expenses to be incurred, I, the undersigned, have insurance and/or employee health care benefits coverage with the above captioned, and hereby assign at clinic's request, and convey directly to **Dr. Dianne Elizabeth Starkey, and Dr. Patrick Starkey** all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services rendered from such doctor and clinic. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the doctor to release all medical information necessary to process this claim. I hereby authorize any plan administrator or fiduciary, insurer and my attorney to release to such doctor and clinic any and all plan documents, insurance policy and/or settlement information upon written request from such doctor and clinic in order to claim such medical benefits, reimbursement or any applicable remedies. I hereby authorize the doctor to release any and all medical information to other healthcare providers involved in my care including but not limited to my primary care physician. I authorize the use of this signature on all my insurance and/or employee health benefits claim submissions.

I hereby convey to the above named doctor and clinic to the full extent permissible under the law and under the any applicable insurance policies and/or employee health care plan any claim, chose in action, or other right I may have to such insurance and/or employee health care benefits coverage under any applicable insurance policies and/or employee health care plan with respect to medical expenses incurred as a result of the medical services I received from the above named doctor and clinic and to the extent permissible under the law to claim such medical benefits, insurance reimbursement and any applicable remedies. Further, in response to any reasonable request for cooperation, I agree to cooperate with such doctor and clinic in any attempts by such doctor and clinic to pursue such claim, chose in action or right against my insurers and/or employee health care plan, including, if necessary, bring suit with such doctor and clinic against such insurers and/or employee health care plan in my name but at such doctor and clinic's expenses.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I have read and fully understand this agreement.

_____ _____

Signature of Insured / Guardian **Date**

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Phone: (330) 336-2120 ~ Fax: (330) 334-8305

Patient Name: _____ **Date:** _____

Terms of Acceptance

The goal of our office is to enable patients to gain control of their health. To attain this we believe communication is the key. There are often topics that are hard to understand and we hope this document will clarify those issues for you.

Please read the below and if you have any questions please feel free to ask one of our staff members.

Informed Consent:

A patient, in coming to the chiropractic doctor, gives the doctor permission and authority to care for the patient in accordance with the chiropractic tests, diagnosis, and analysis. The chiropractic adjustment or other clinical procedures are usually beneficial and seldom cause any problems. In rare cases, underlying physical defects, deformities or pathologies may render the patient susceptible to injury. The doctor, of course, will not give any treatment or care if he/she is aware that such care may be contra-indicated. Again, it is the responsibility of the patient to make it known, or to learn through healthcare procedures what he/she is suffering from: latent pathological defects, illnesses or deformities which would otherwise not come to the attention of the chiropractic physician. The chiropractic doctor provides a specialized, non-duplicating health care service. Your Doctor of Chiropractic is licensed in a special practice and is available to work with other types of providers in your health care regimen. I understand that if I am accepted as a patient by Dr. Dianne Elizabeth Starkey, and Dr. Patrick Starkey I am authorizing them to proceed with any treatment that they deem necessary. Furthermore, any risk involved, regarding chiropractic treatment, will be explained to me upon my request.

Women Only:

To the best of my knowledge I **am / am NOT** pregnant and (**give my permission / don't give permission**) to x-ray me for diagnostic interpretation.
(Circle one above) *(Circle one above)*

Missed Appointments:

There is a possible fee charged for all appointments that are not canceled prior to scheduled visit.
Any appointment that is not canceled 24 hours prior to scheduled appointment will be charged $45 - $70.
The fee will be based on the type of appointment that was scheduled.

Consent to Evaluate and Treat a Minor:

I, _____ being the parent or legal guardian of _____, have read and fully understand the above terms of acceptance and hereby grant permission for my child to receive chiropractic care.

Communications:

In the event that we would need to communicate your healthcare information, to whom may we do so?

Spouse: _____

Children: _____

Others: _____

No one: ____

May we leave messages regarding your personal healthcare information on any answering device,
i.e. home answering machines, voicemails, emails, text message? Yes [ ] No [ ]

Acknowledgement

I have read and fully understand the above statements. I have reviewed the notice of privacy practices (HIPAA) and have been provided an opportunity to discuss my right to privacy. Upon request I will be given a copy.

Print Name: _____

Signature: _____ Date: _____

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PATIENT FINANCIAL POLICY

Our primary responsibility is to help you experience good health and we wish to spend our time and energy toward that end. In the interest of good health care practice, it is best to establish a financial policy to avoid misunderstanding.

1. **All accounts are due and payable at the time of your visit unless you make satisfactory arrangements with the office manager.**
2. **It is our policy that if we are filing a claim with your insurance company, we will expect you to pay any unpaid deductible as well as the copayment/coinsurance required by your insurance company at the time of your visit.**
3. **Even though you may have an insurance claim pending, you will receive a statement each month for the outstanding balance of your account. We cannot accept responsibility for collecting an insurance claim or negotiating a disputed claim.**
4. **Remember, insurance reimbursement is a contract between you and your insurance carrier. If after 45 days your insurance has not been paid, we will turn to you for payment. You are responsible for your bills regardless of what your insurance pays.**
5. **If for any reason you have an unpaid balance at 60 days past due, we will automatically charge you $5.00 per month on your unpaid balance.**
6. **To better serve all of our patients, we request that you inform us at least twenty-four hours in advance if you need to cancel your appointment. If for any reason you fail to do this, we will bill you (not your insurance company) for an office visit.**
7. **There will be a $25.00 charge on all returned checks, per submission.**
8. **We do not wish to cause you any undue hard ship, however, we must be able to continue our service to the community.**

I have read this financial policy and understand that, regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limits of this credit policy. I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay all such costs and fees, including collection costs, Attorney's fees and all court costs.

_____ _____

DATE **PARTY RESPONSIBLE FOR ACCOUNT**

Dr. Dianne Elizabeth Starkey, Dr. Patrick Starkey, Dr. Anthony Berardino, Dr. Kellee Leonard
237 Leatherman Rd Wadsworth Ohio 44281

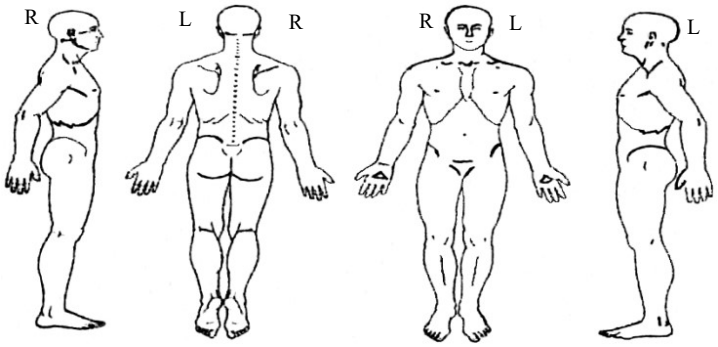
PEDIATRIC CASE HISTORY

Name: _____ New Patient____ Re-evaluation___

WELLNESS CHECK UP ___YES or ___ NO If there is a health concern, please proceed below

1. **Describe each Condition / Problem**	**Severity** (0=no pain, 10- very severe)	**Frequency** Intermittent	Occasional	Frequently	Constant
A)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
B)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%
C)_____	0 1 2 3 4 5 6 7 8 9 10	0 -25%	26-50%	51-75%	76-100%

(Please mark the figures where you experience pain.)



2. Symptoms are worse in the (circle what applies)

-morning -Increase during the day
-afternoon -same all day
-night -decrease during the day

3. Symptom (a.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
4. Symptom (b.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
5. Symptom (c.) is: Sharp / Dull / Burning / Aching / Throbbing / Numbness / Tingling / Pins & Needles
6. Date of Onset: _____ or when you last experienced the condition: _____weeks/months/years ago
   a. __ Acute (within last 3 months) __ Recurrent (multiple episodes <3 months) __ Chronic (continuous > 3 months)
7. How did your symptoms begin? (Cause)_____
8. Have you experienced these before? When?_____
9. Has your condition? ____ Improved ____ Gotten worse ____ Stayed the same since it began
10. Circle the activities that make your problems worse:

    Bending - Lying - Walking - Standing - Sitting - Movement - Twisting - Lifting - Sleeping

11. Is there anything you can do to relieve the problems? ____No ____Yes Describe: _____

    If No, what have you tried that has not helped? _____
12. Have you been treated for this before? ___No ___Yes Who/How long ago? _____
13. What treatment did you receive? _____
14. Results of previous treatment? ___Good ___Poor Comments _____
15. Which activities of daily living does this pain interfere with?_____
16. List any other major injuries you have had, other than those mentioned above: _____

_____

I certify that the above information is accurate to the best of my knowledge.

Patient/Guardian Signature _____ Date: _____

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Pediatric Chiropractic Health Questionnaire

Patient Name:_____ Date:_____
Date of last: Physical Exam_____Spinal X-ray_____

Blood test_____ Spinal exam_____X-ray, MRI, CT, bone scan_____

Accidents or injuries: (Include Date)_____

Surgeries or Hospitalizations: (Include Date)_____
Other Medical Procedures:

_____
Name and dosages of medications or supplements_____

_____

Immunizations:_____

_____

Allergies:_____

Pharmacy Name_____City, Phone_____

Sleep_____ hrs/night Naps_____#/day _____mins or hours /nap

Sleep pattern regular or irregular: Please explain_____

Smokers in the home: Yes___ No___ who?_____ Pets in the Home: Yes___ No___
O Daycare O Preschool O School O Home Started at what age?____

HISTORY OF PREGNANCY
Any illnesses of the mother during pregnancy?_ Yes or No

_____
O Abnormal Bleeding O High Blood Pressure O Trauma O Infection O Rupture O Diabetes O Swollen Ankles

Any supplements or medication during pregnancy?__ Yes___ No ___
List:_____

Any smoking/drugs/chemical exposure during pregnancy? Yes ___ No___
Number of ultrasounds___ Reason:_____

Stress level (circle): No stress -1 2 3 4 5 6 7 8 9 10- Extremely Stressed

HISTORY OF BIRTH

Place of delivery: _____Hospital/Birthing Center/Home Birth

Name of Prenatal care Provider:_____ OB/MD/Midwife/Other
Duration of Gestation:_____Duration of labor:_____Hours/Days
Birth weight/ length:_____lbs_____oz _____inches
Complications of labor or delivery:_____

Check off the following that describes your child's birth:

- ◯ Long and / or difficult
- ◯ Forceps
- ◯ Vaccum extraction
- ◯ Caesarean
- ◯ Epidural
- ◯ Breech
- ◯ Induced
- ◯ Unmedicated/Unassisted

Was your child alert and responsive within 12 hours of delivery: Yes or No
Please explain: _____

Any birth trauma including bruising/fractures/getting stuck in birth canal:_____
Breastfed/Formula Fed and for how long:_____

When did the child meet these milestones:

Sitting Up: _____ Months or Never

Grasping_____ Months or Never

Crawling _____Months/Year or Never

Pulled to Stand_____ Months or Never

Walked Unassisted_____ Months or Never

Potty Trained_____ Months/Year or Never

Dry at Night _____Months/Year or Never

First Words _____Months/Year or Never

Spoke Simple sentences_____Months/Year or Never

Spoke clearly_____Months/Year or Never

Conditions: Please check any that apply to you:

- o Anemia
- o Appendicitis
- o Asthma
- o Bleeding Disorders
- o Bronchitis
- o Cancer
- o Chemical Dependency
- o Chicken Pox
- o Colic
- o Diabetes
- o Ear Infections
- o Epilepsy
- o Flu
- o Fractures
- o Glaucoma
- o Goiter
- o Heart Disease
- o Hepatitis
- o Herpes
- o HIV positive
- o Kidney disease
- o Liver disease
- o Measles
- o Migraine headaches
- o Mononucleosis
- o Mumps
- o Pink Eye
- o Pneumonia
- o Psychiatric care
- o Rheumatic fever
- o Scarlet fever
- o Thyroid problems
- o Tonsillitis
- o Tuberculosis
- o Tumors, growths
- o Ulcers
- o Whooping cough
- o Other:_____

Does/Did any of your immediate family members have any health conditions:

_____

_____

_____

General Symptoms: Check any symptom you currently have or had in the past.

General

- ◯ Attention disorder
- ◯ Bruise easily
- o Chills
- o Difficulty sleeping
- o Dizziness
- o Fainting
- o Fever
- o Headache
- o Loss of sleep
- o Loss of weight
- o Nervousness
- o Numbness
- o Sweats Day/Night
- o Tiredness
- o Weight gain

Genito-Urinary

- o Blood in urine
- o Frequent Urination
- o Lack of bladder control
- o Painful Urination
- o Yeast Infection
- o Urinary Tract Infections

Gastro-intestinal

- o Poor appetite
- o Bloating
- o Bowel changes
- o Colic
- o Constipation
- o Diarrhea
- o Excessive hunger
- o Excessive thirst
- o Gas
- o Hemorrhoids
- o Indigestion
- o Nausea
- o Rectal bleeding
- o Stomach pain
- o Vomiting
- o Vomiting blood

Other Health Conditions:____
_____
_____
_____
_____

Eye, ears, nose throat

- o Bleeding gums
- o Blurred vision
- o Crossed eyes
- o Difficulty swallowing
- o Double vision
- o Earache
- o Ear Infection
- o Ear discharge
- o Hay fever
- o Hoarseness
- o Loss of hearing
- o Nosebleeds
- o Persistent cough
- o Ringing in ears
- o Sinus problems
- o Vision-flashes
- o Vision-halos

Skin

- o Bruise easily
- o Hives
- o Itching
- o Change in moles
- o Rash
- o Scars
- o Sores that won't heal

Cardiovascular

- o Chest pain
- o Irregular heart beat
- o Low blood pressure
- o Poor circulation
- o Rapid heart beat
- o Swelling of ankles
- o Varicose veins

Neck, Back and Extremities Check symptoms you are currently having or have had in the past year.

Neck

- o Pain in neck
- o Neck Stiffness
- o Pinched nerve
- o Neck feels out of place
- o Muscles spasms in neck
- o Grinding/popping sounds in neck

Shoulders

- O Pain in Shoulder joint O Right O Left
- o Pain across Shoulders
- o Can't raise arm O Right O Left
- o Tension in shoulders
- o Pinched nerve in shoulder O Right O Left

Mid-back

- o Mid-back pain
- o Mid- back stiffness
- o Pain between shoulder blades
- o Muscle spasms in mid-back

Arms and hands

- o Pain in upper arm O Right O Left
- o Pain in elbow O Right O Left
- o Pain in forearm O Right O Left
- o Pain in hand O Right O Left
- o Pain in fingers
- o Pins and needles in arm O Right O Left
- o Pins and needles in fingers O Right O Left
- o Weakness in arms O Right O Left
- o Weakness in hands O Right O Left
- o Hands are cold O Right O Left

Low back

- o Low back pain
- o Low back stiffness
- o Low back weakness
- o Pinched nerve in back
- o Low back feels out of place
- o Muscle spasms in back
- O Sciatic pain

Hips, legs and feet

- o Pain in buttocks O Right O Left
- o Pain in hip joint O Right O Left
- o Pain down leg O Right O Left
- o Pain in knee O Right O Left
- o Pain in ankle O Right O Left
- o Pain in foot O Right O Left
- o Weakness in leg O Right O Left
- o Weakness in knees O Right O Left
- o Leg cramps O Right O Left
- o Pins and needles O Right O Left
- o Other Symptoms_____
  _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of her staff responsible for any errors or omission that I may have made in the completion of this form.

Patient/Guardian Signature _____ Date: _____