Dr Joseph Moran 640 Washington Ave.
Larksville, Pa 18651
570-417-7613

Welcome to our Office

CASE HISTORY

Name _____ _____ Age _____ Date _____

Address _____ City _____ State _____ Zip _____

Phone (home) _____ Date of Birth _____

Sex: _____ Marital Status: _____ Number of Children _____

Cell Phone _____ E-mail _____

Occupation: _____ Employer _____ Phone(work) _____

Spouse Name _____ Spouse Occupation _____

Spouse Employer _____ Spouse work phone _____

To whom may we thank for referring you: _____

Passed Chiropractic Care: _____ When _____

Medical Doctor _____ M.D. Phone _____

Other Doctor/Therapist _____ Other Phone _____

Are your present problems due to an injury? _____

Cause of Injury _____

Has the accident been reported? _____ To Employer _____ Auto Carrier _____

Have you now or have you ever been disabled? (Service or Work) _____ Date of Disability _____

What was or is your cause of disability?

_____

Have you retained an attorney? _____

Attorney _____ Attorney's Phone _____

Habits

_____ Smoking Packs/Day

_____ Alcohol Drinks/Day

_____ Coffee (Caffeine) Cups/Day

Exercise

_____ ☐ None

_____ ☐ Occasional

_____ ☐ Daily

Type of exercise _____

Family History

	Diabetes	Heart	Kidney	Cancer	Back
Mother	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐
Brother, No of ___	☐	☐	☐	☐	☐
Sister, No of ___	☐	☐	☐	☐	☐

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Name _____ Date _____

Have you had any of the following diseases

- ☐ Appendicitis
- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ WhoopingCough
- ☐ Anemia
- ☐ Measles
- ☐ Mumps
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Goiter
- ☐ Influenza
- ☐ Pleurisy
- ☐ Alcoholism
- ☐ Venereal Infection
- ☐ Arthritis
- ☐ Epilepsy
- ☐ MentalDisorder
- ☐ Lumbago
- ☐ Eczema
- ☐ HIV Positive

Previously	Presently	General Symptoms
☐	☐	Allergy
☐	☐	Bronchitis
☐	☐	Chills
☐	☐	Convulsions
☐	☐	Dizziness
☐	☐	Fainting
☐	☐	Fatigue
☐	☐	Fever
☐	☐	Headache
☐	☐	Loss of Sleep
☐	☐	Loss of weight
☐	☐	Nervousness
☐	☐	Neuralgia
☐	☐	Night Sweats
☐	☐	Numbness or pain in arms/legs/hands
☐	☐	Wheezing

Previously	Presently	Gastro-Intestinal
☐	☐	Belching or gas
☐	☐	Colon Trouble
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Excessive hunger
☐	☐	Gall Bladder trouble
☐	☐	Hemorrhoids (Piles)
☐	☐	Jaundice
☐	☐	Liver Trouble
☐	☐	Nausea
☐	☐	Pain over Stomach
☐	☐	Poor Appetite
☐	☐	Poor Digestion
☐	☐	Vomiting
☐	☐	Vomiting Blood

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Name _____ Date _____

Muscle & Joints

Previously	Presently	
☐	☐	Backache
☐	☐	Foot Trouble
☐	☐	Hernia
☐	☐	Pain Between Shoulders
☐	☐	Painful Tail Bone
☐	☐	Sciatica
☐	☐	Stiff Neck
☐	☐	Spinal Curvature
☐	☐	Swollen Joints
☐	☐	Tremors
☐	☐	Twitching
☐	☐	Weakness

Cardio-vascular

Previously	Presently	
☐	☐	High Blood Pressure
☐	☐	Low Blood Pressure
☐	☐	Pain over heart
☐	☐	Poor Circulation
☐	☐	Heart Trouble
☐	☐	Rapid Heart
☐	☐	Slow Heart
☐	☐	Stroke
☐	☐	Swelling in Ankles
☐	☐	Varicose Veins

Eye/ Nose/ Throat

Previously	Presently	
☐	☐	Asthma
☐	☐	Crossed Eyes
☐	☐	Deafness
☐	☐	Earache
☐	☐	Ear Discharge
☐	☐	Ear Noises
☐	☐	Enlarged Thyroid
☐	☐	Frequent Colds
☐	☐	Hay Fever
☐	☐	Hoarseness
☐	☐	Nasal Obstruction
☐	☐	Nose Bleeds

Eye/ Nose/ Throat cont.

Previously	Presently	
☐	☐	Pain in Eyes
☐	☐	Poor Vision
☐	☐	Sinusitis
☐	☐	Sore Throat
☐	☐	Tonsillitis
☐	☐	Respiratory

Respiratory

☐	☐	Chest Pain
☐	☐	Chronic Cough
☐	☐	Difficulty Breathing
☐	☐	Spitting Blood
☐	☐	Spitting Phlegm

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Name _____ _____ Date _____

Previously	Presently	Skin or Allergies
☐	☐	Boils
☐	☐	Bruising Easily
☐	☐	Dryness
☐	☐	Eczema
☐	☐	Hives or Allergy
☐	☐	Itching
☐	☐	Sensitive Skin
☐	☐	Skin Eruptions

Previously	Presently	Genito-urinary
☐	☐	Bed wetting
☐	☐	Blood in Urine
☐	☐	Frequent Urination
☐	☐	Inability to Control Urine
☐	☐	Kidney Infection
☐	☐	Painful Urination
☐	☐	Prostate Trouble

Previously	Presently	For Women Only
☐	☐	Cramps or Backache
☐	☐	Excessive Flow
☐	☐	Hot Flashes
☐	☐	Irregular Cycle
☐	☐	Miscarriage
☐	☐	Painful Periods
☐	☐	Vaginal Discharge

Pregnant at this time _____

Last Pap Date _____ Date of Last Menstrual Period _____

By whom _____ _____

Operations and Procedures

_____	Vaccinations	_____	Tubes in Ears	_____	Sinus
_____	Tonsillectomy	_____	Appendectomy	_____	Hernia
_____	Gall Bladder	_____	Female Organs	_____	Thyroid

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Name Date

Operations and Procedures Cont.

Back Operation Rectal Surgery Stomach
Other Other
Other Other
I have never had any operations or surgeries

List any accidents or falls and dates:

Car Recreational Vehicle
Boat Sport School
Other Other

List any broken bones (fractures) or dislocations:

Ever on Crutches Why:

Have you ever had any spinal taps or spinal injections?

Have you ever had a lapse of memory?

Have you ever had X-rays taken?

Date Why
Date Why
Date Why

Do you suffer from any condition other than that for which you are now consulting our office?

Are you presently taking any medication perscription as well as over the counter?

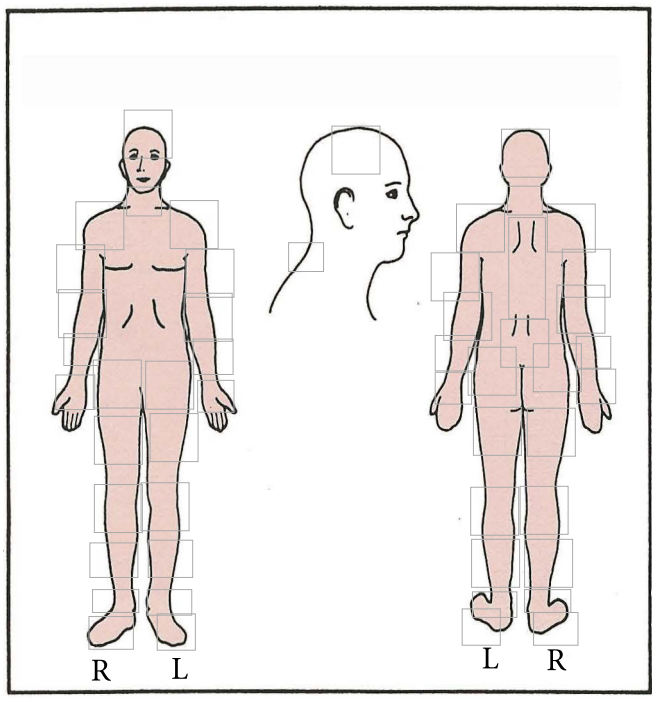
Vitamins and Supplements

Height ft inches
Weight lbs.
Shoe Size Shoe width

Name _____ _____ Date _____

CC: What brings you in today?

- ☐ Headache Date of Onset
- ☐ Neck Pain Date of Onset
- ☐ Upper Back Pain Date of Onset
- ☐ Low Back Pain Date of Onset
- ☐ ☐ S-I Joint Pain Date of Onset
- ☐ ☐ Hip Pain Date of Onset
- ☐ ☐ Shoulder Pain Date of Onset
- ☐ ☐ Arm Pain Date of Onset
- ☐ ☐ Elbow Pain Date of Onset
- ☐ ☐ Forearm Pain Date of Onset
- ☐ ☐ Wrist Pain Date of Onset
- ☐ ☐ Leg Pain Date of Onset
- ☐ ☐ Knee Pain Date of Onset
- ☐ ☐ Lower Leg Pain Date of Onset
- ☐ ☐ Ankle Pain Date of Onset
- ☐ ☐ Foot Pain Date of Onset
- ☐ ☐ Other Date of Onset



1. Mark with an ☑ in the area(s) you are feeling symptoms
2. On the chart below select the appropriate level of symptoms.
3. Select how often you feel each of these symptoms.
4. List any activities since your last visit that you were unable to do or that made you notice your symptoms more.

Please select the following response.

I ☐ been in a car (or other) accident since my last visit.

Please check the appropriate # to describe your Present Pain level: With 0 being Normal/ or no pain; and 10 being very severe pain.

Area of Pain	Severity of Pain	Frequency of Pain

I have new symptoms due to: _____

My symptoms were more noticeable due to: _____

Due to my symptoms I can not perform my activities of:

_____

Joint Notice of Privacy Practices

This is a Joint Notice of Privacy Practices for:
Dr Joseph Moran

Purpose: This Joint Notice of Privacy Practices ("Notice") presents the information that federal law requires us to give our patients regarding our privacy practices.

We must provide this Notice to each patient beginning no later than the date of our first service delivery to the patient, including service delivered electronically, after July 1, 2024. We must make a good faith attempt to obtain written acknowledgment of receipt of the Notice from the patient. We must also have the Notice available at the office for patients to request to take with them. We must post the Notice in our office in a clear and prominent location where it is reasonable to expect any patients seeking service from us to be able to read the Notice and on our website. Whenever the Notice is revised, we must make the Notice available upon request on or after the effective date of the revision in a manner consistent with the above instructions. Thereafter, we must distribute the Notice to each new patient at the time of service delivery and to any person requesting Notice. We must also post the revised Notice in our office as discussed above.

Dr Joseph Moran is required to provide you with this Notice pursuant to the privacy regulations implementing the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") ("**Privacy Rules**"). Dr Joseph Moran consists of the entities listed above. These entities are "affiliated covered entities" and an "organized health care arrangement" within the meaning oaf the Privacy Rules. This Notice applies to all Dr Joseph Moran practice locations in Pennsylvania.

Joint Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR OBLIGATIONS

We are required by law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal obligations, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect July 01, 2024, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available to you when you first receive services from us after the date the revised Notice becomes effective or upon request.

You may request a copy of our Notice at any time. For more information about privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for our treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other health care provider providing treatment to you.

Payment: We may use or disclose your health information to your health insurer to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities. For example, we may use or disclose your health information in order to conduct an internal assessment of the quality of care we provide.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification (including identifying or locating) a family member, your personal representative or another person responsible for your care, to the extent necessary to help with your health care or with payment of your health care, if you agree that we may do so. We may also advise these persons of your locations, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Disclosures Permitted or Required by Law: We are permitted and in some cases required, by law to make certain other disclosures of health information without your consent. We may disclose your health information, if appropriate, to the following entities under the following circumstances:

1. to public health agencies to satisfy certain reporting requirements, such as births and deaths, certain communicable diseases, child abuse and other public health issues;
2. to health oversight agencies such a governmental auditors, the Pennsylvania Agency for Health Care Administration, the Pennsylvania Department of Health and other agencies when required;
3. to any individual when Dr Joseph Moran is ordered by a court or other legal process to do so;
4. to law enforcement officials when necessary for law enforcement purposes and required by law;
5. to a coroner or medical examiner when necessary to enable them to perform their duties;
6. to organ procurement organizations, to enable them to make suitability determination;
7. in case of emergency; or
8. to researches if their research has been approved by an institutional review board and they take certain steps to protect your privacy.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as a voicemail messages, postcards, emails or letters) or information about treatment alternatives or other health related benefits and services that may be of interest to you.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Your Authorization: Other uses and disclosures of your health information will be made if you give us written authorization to do so. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

PATIENT RIGHTS

You have certain rights regarding your health information. These rights include:

1. the right to obtain a paper copy of this Notice:
2. the right to inspect and copy your health information (copies are available for a reasonable fee);
3. the right to request amendments to your health information you believe to be inaccurate;
4. the right to obtain an accounting of Dr Joseph Moran's uses and disclosures of your health information, subject to certain exceptions;
5. the right to request restrictions on our permitted uses and disclosures of your information (although we are not legally obligated to honor this request; and
6. the right to request that communications regarding your health information be sent by alternative means or at alternative locations.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights or wish to exercise any of your rights described herein, please contact using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the Privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Joseph Moran, DC

Telephone:570-417-7613

Email:drmoran@drjosephmoran.com

Address: 640 Washington Ave., Larksville, Pa 18651

DrJoseph Moran DC
640 Washington Ave.
Larksville, Pa 18651
570-417-7613

Patient Acknowledgement of Notice of Privacies

Effective April 14, 2003, the federal HIPPA privacy rule requires our practice to comply with certain legal requirements designed to protect your personal health information. HIPPA gives individuals the right to request a restriction on uses and disclosure of protected health information (PHI). The individual is also provided the right to request confidential communication of PHI be made by alternative means, such as sending correspondence to the individuals office instead of home. We may need your written authorization to release PHI even if you are the one requesting the release.

I wish to be contacted in the following matter.
Check all that apply and list of numbers:

You can communicate information about me to the following people.

Patient or Legal Guardian Signature

Date

By signing above, I acknowledge that I have read Dr Joseph Moran, DC's notice of Privacy Practices

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
(Print Patient's Name)

office's Notice of Privacy Practices.

_____
Signature of Patient or Legal Representative

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communications barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

_____
_____
_____
_____
_____
_____
_____
_____

ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this
(Print Patient's Name)

office's Notice of Privacy Practices.

_____
Signature of Patient or Legal Representative

_____

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Dr. Joseph Moran
640 Washinton Ave
Larksville, PA 18651

Informed Consent to Chiropractic Treatment

The nature of chiropractic treatment: The doctor will use his/her hands or a mechanical device in order to move your joints. You may feel a "click" or "pop", such as the noise when a knuckle is "cracked", and you may feel movement of the joint. Various ancillary procedures, such as hot or cold packs, electric muscle stimulation, electrical acupuncture,` therapeutic ultrasound or dry hydrotherapy may also be used.

Possible Risks: As with any health care procedure, complications are possible following a chiropractic manipulation. Complications could include fractures of bone, muscular strain, ligamentous sprain, dislocations of joints, or injury to intervertebral discs, nerves or spinal cord. Cerebrovascular injury or stroke could occur upon severe injury to arteries of the neck. A minority of patients may notice stiffness or soreness after the first few days of treatment. The ancillary procedures could produce skin irritation, burns or minor complications.

Probability of risks occurring: The risks of complications due to chiropractic treatment have been described as "rare", about as often as complications are seen from the taking of a single aspirin tablet. The risk of cerebrovascular injury or stroke, has been estimated at one in one million to one in twenty million, and can be even further reduced by screening procedures. The probability of adverse reaction due to ancillary procedures is also considered "rare".

Other treatment options which could be considered may include the following:

- *Over-the-counter analgesics.* The risks of these medications include irritation to stomach, liver and kidneys, and other side effects in a significant number of cases.
- *Medical care,* typically anti-inflammatory drugs, tranquilizers, and analgesics. Risks of these drugs include a multitude of undesirable side effects and patient dependence in a significant number of cases.
- *Hospitalization* in conjunction with medical care adds risk of exposure to virulent communicable disease in a significant number of cases.
- *Surgery* in conjunction with medical care adds the risks of adverse reaction to anesthesia, as well as an extended convalescent period in a significant number of cases.

Risks of remaining untreated: Delay of treatment allows formation of adhesions, scar tissue and other degenerative changes. These changes can further reduce skeletal mobility, and induce chronic pain cycles. It is quite probable that delay of treatment will complicate the condition and make future rehabilitation more difficult.

Unusual risks: I have had the following unusual risks of my case explained to me.
I have read the explanation above of chiropractic treatment. I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment. I have freely decided to undergo the recommended treatment, and herby give my full consent to treatment.

_____	_____	_____
Printed Name	**Signature**	**Date**

WITNESS:

_____	_____	_____
Printed Name	**Signature**	**Date**

Print all pages