DR. STEPHEN J. WOHAR
727 ROUTE 481, MONONGAHELA, PA 15063
724-258-3371

CONFIDENTIAL PATIENT INFORMATION

Name _____ Date _____

How would you like us to address you in our office (Mr., Mrs., Nickname, etc.): _____

Phone: Home _____ Work _____ Ok to call you at work if necessary?

Cell _____ ☐ Yes ☐ No

Address _____ City, State, Zip _____

Age ____ Date of Birth _____ Soc. Security # _____ Occupation _____

Marital Status (circle one) M S W D Name of Spouse _____

Person to contact in an emergency _____ Phone _____

Referred to our office by:

- ☐ Friend _____
- ☐ Relative _____
- ☐ Yellow Pages _____
- ☐ Health Professional _____
- ☐ Other _____

Have you had chiropractic care before? ☐ Yes ☐ No

If yes, last adjustment? _____

What is your major complaint? _____

Date symptoms occurred _____ Ever have this condition before? ☐ Yes ☐ No

Do you know what caused the pain? _____

Is the pain constant or does it come and go? _____

Is it getting worse? ☐ Yes ☐ No

Have other doctors treated you for this complaint? (please specify) _____

_____

This condition interferes with my:

- ☐ Work (explain) _____
- ☐ Sleep _____
- ☐ Daily Routine (explain) _____
- ☐ Other _____

MEDICAL HISTORY

Previous surgeries (include dates) _____

Have you ever been involved in an auto accident? ☐ No ☐ Yes: Date(s) _____

If yes, please describe: _____

Have you ever had any other personal injury or accident? ☐ No ☐ Yes: Date(s) _____

If yes, please describe: _____

Medication(s) you now take: _____

Vitamin supplements: _____

Female Only: Is there a chance you could be pregnant? ☐ Yes ☐ No Date of last period _____

PERSONAL HABITS

Sleeping: _____ hours per night

Coffee/Tea: _____ cups per day

Smoking/Tobacco: _____ per day

Alcohol: _____ per day/week

CIRCLE ANY OF THE FOLLOWING PROBLEMS YOU NOW HAVE

Abdominal pain
Allergies
Anxiety
Arthritis
Asthma
Blood pressure prob.
Cancer
Cold feet or hands
Cold sweats
Constipation
Depression
Diabetes
Diarrhea
Disc problems
Dizziness
Ear disorders
Fatigue
Head seems heavy
Headache
Heartburn
Knee pain
Loss of balance
Low-back pain
Mid-back pain
Neck pain
Nervousness/Tension
Numbness in arms/legs
Overweight/Obese
Pins/Needles in arms/legs
Short of breath
Shoulder pain
Sinus trouble
Sore throats
Spinal surgery
Stroke
Urinary problems
Female Only:
- Menstrual problems:
  - Spotting
  - Cramps
  - Irregular periods
  - PMS symptoms

Male Only:
- Impotency
- Prostrate problems:
  - Frequent urination
  - Painful urination
  - Lack of control

FINANCIAL INFORMATION

Person responsible for payment _____ Relationship to patient _____

How will payment of this account be made? ☐ Cash/Check (not using insurance) ☐ Health Insurance*

**if you are planning on using your insurance, please give your identification card(s) to the receptionist so that coverage may be verified*

What type of insurance plan(s) do you have? _____

I assume full responsibility for the payment of services and agree to pay for them in full, AT THE TIME OF SERVICE, unless other arrangements are made with the office.

_____ _____

Patient/Legal Guardian Signature Date

PAIN DRAWING

Patient Name: _____ Date: _____

Date of Birth: _____

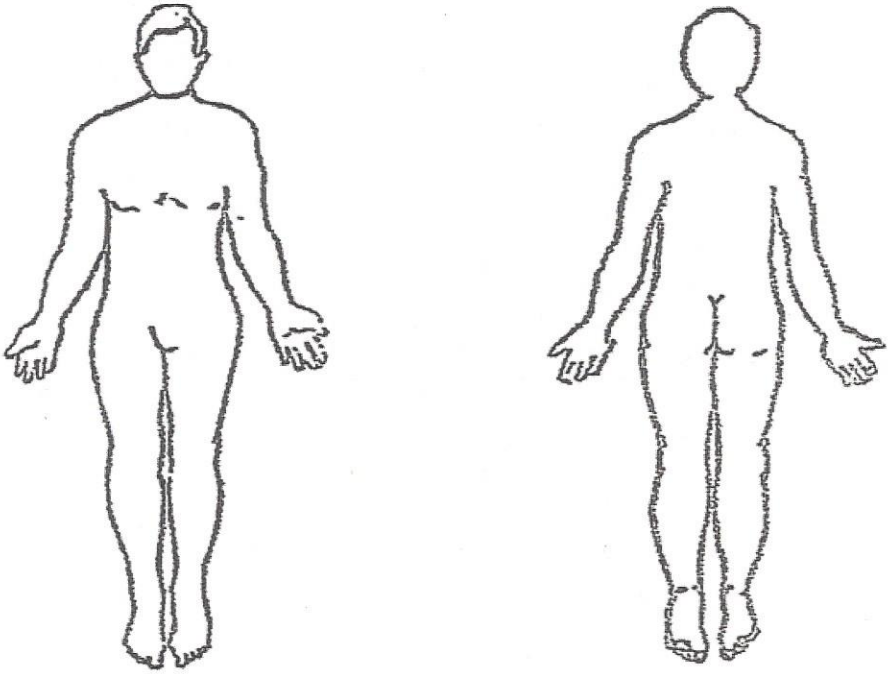
Borg Pain Scale

On a scale of 1 to 10, Place and "x" in your current pain level

Normal	Low Pain	Moderate Pain	Intense Pain	Emergency
( ) 0	( ) 1	( ) 4	( ) 7	( ) 10
	( ) 2	( ) 5	( ) 8	
	( ) 3	( ) 6	( ) 9	

Ransford Pain Drawing

To help us better understand the nature and origins of your complaints, we ask that you carefully complete this drawing. Use the symbols listed below to detail where you hurt and how it hurts.



//////// Dull Ache/Throb

XXXXX Sharp/Stabbing

BBBBB Burning

Numbness

:::::::::: Tingling

SSSSSS Cramping

Patient Signature: _____ Date: _____

Form: LMW 714

Dr. Stephen J. Wohar

727 Route 481
Monongahela, PA 15063

Phone: 724-258-3371
Email: drwohar@verizon.net

INSURANCE AUTHORIZATION FORM

I authorize Dr. Stephen J. Wohar and office staff to release pertinent information to my health insurance carrier about my medical condition for the purpose of securing health insurance benefits information, authorization, and/or payment for services performed. I also authorize my insurance to issue payment directly to Dr. Stephen J. Wohar, the Doctor rendering service. I understand that all or a portion of my benefits may be paid by my health insurance carrier, and that I will be responsible for any balance owed on the services rendered. I will provide Dr. Stephen J. Wohar and office staff a current copy of my insurance identification card and all accompanying insurance information.

I understand that I may revoke this authorization at any time by giving Dr. Stephen J. Wohar and office staff a statement to withhold my personal and medical information from that time forward.

PRIMARY INSURANCE CARRIER INFORMATION

Insurance Company & Plan Name: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Patient's Relationship to Subscriber: _____ ID Number: _____

SECONDARY INSURANCE CARRIER INFORMATION

Insurance Company & Plan Name: _____

Subscriber Name: _____ Subscriber Date of Birth: _____

Patient's Relationship to Subscriber: _____ ID Number: _____

AUTHORIZATION

Patient's Name: _____ Date: _____

Patient or Legal Guardian's Signature: _____

Print Patient Name _____