Dr. Brad Todaro at
Allegheny Advanced
Chiropractic

1900 Wa. dam Plaza Drive
McMurray, PA 15317
(724) 942-7660
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PATIENT INFORMATION

Date: _____

Name: _____
First Name

_____
Last Name Middle Initial Nickname

Address: _____

City: _____ State: _____ Zip: _____

SS#: _____ Sex: ❑ Male ❑ Female

Date of Birth: _____ Age: _____

❑ Married ❑ Single ❑ Widowed
❑ Separated ❑ Divorced ❑ Minor

Race: ❑ African American ❑ Asian ❑ Black
❑ Caucasian ❑ Other _____

Ethnicity: ❑ American ❑ Hispanic ❑ Indian ❑ American Indian
❑ Chinese ❑ Japanese ❑ Latino
❑ Other _____

Preferred Language: English, Spanish, Other _____

Employer: _____

Employer Address: _____

Occupation: _____

Spouse's or Parent's Name: _____

SS#: _____ B-day: _____

Employer: _____ Occupation: _____

Whom may we thank for referring you to us? _____

INSURANCE INFORMATION

Work or Auto Related? _____ Med Pay Coverage? _____

Policy Holder's Name: _____

Relationship to Patient: _____

Insurance Company: _____

Is patient covered by additional insurance? ❑ Yes ❑ No

Person responsible for account if other than self?
Name: _____

Address: _____ Phone: _____

ACCIDENT INFORMATION

Is condition due to an accident? ❑ Yes ❑ No Date: _____

Type of accident: ❑ Auto ❑ Work ❑ Other: _____

To whom have you made a report of your accident?

❑ Auto Insurance ❑ Employer ❑ Worker's Comp ❑ Other

Claim Number (if applicable): _____

Attorney's Name (if applicable): _____

PHONE NUMBERS

Home Phone: (_____) _____

Work Phone: (_____) _____

Cell Phone: (_____) _____

Cell Phone Carrier: _____

Email Address: _____

Contact Preference: ❑ Cell ❑ Home
❑ Work ❑ Email ❑ Any

IN CASE OF EMERGENCY, PLEASE CONTACT:

Name: _____ Relationship: _____

Home Phone: (_____) _____

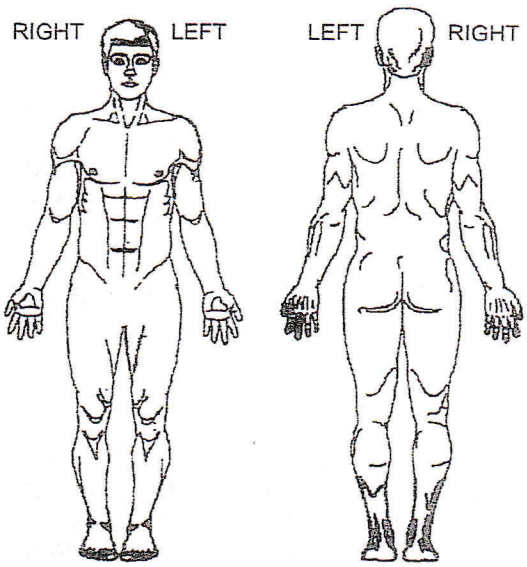
Cell Phone: (_____) _____

PAIN DIAGRAM

Please complete the following "Pain Diagram" by using letters to indicate your areas of pain.

P.	PAIN
T.	TINGLING
N.	NUMBNESS
B.	BURNING
S.	STIFFNESS

FRONT BACK



Initial Here _____

How did you hear about our office? _____

Medical Conditions: (Circle all that apply to you)

Arthritis	Cancer	Diabetes	Heart Disease
Hypertension	Psychiatric Illness	Skin Disorder	Stroke
Other _____	Fibromyalgia	Asthma	Osteoporosis

Surgeries: (Circle all that apply to you)

Appendectomy	Cardiovascular procedure	Cervical spine	Hysterectomy
Joint Replacement	Prostate	Lumbar spine	Gall Bladder
Brain	Shoulder	Thoracic spine	Knee
Carpal Tunnel	Gastro-intestinal	Uro-genital	Hernia
Breast Augmentation	Other _____		

Allergies: (Circle all that apply to you)

Mold	Seasonal	Milk or Lactose	Animal
Chemical _____	Sulfites	Wheat/Glutens	Other _____

Social History: (Circle all that apply to you)

Caffeine use:	occasional	often	never
Drink Alcohol:	occasional	often	never
Exercise:	occasional	often	never
Drink Water:	<64 oz/day	>64 oz/day	never
Cigarettes:	<1 pack/day	>1 pack/day	never
Sleep:	<8 hours/night	>=8 hours/night	Insomnia

Other _____

Family History: (Circle all that apply)

Arthritis:	Parent	Sibling
Cancer:	Parent	Sibling
Diabetes:	Parent	Sibling
Heart Disease	Parent	Sibling
Hypertension	Parent	Sibling
Stroke	Parent	Sibling
Thyroid	Parent	Sibling

Other _____

Occupational Activities: (Circle one that best describes your job description)

Administration	Business Owner	Clerical/Secretary	Computer User
Heavy Equipment operator	Daycare/Childcare	Construction	Health Care
Food Service Industry	Medium Manual Labor	Manufacturing	Home Services
Heavy Manual Labor	Light Manual Labor	Executive/Legal	Housekeeper

Other _____

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to treat my condition as he or she deems appropriate. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient Signature:_____ **Date:**_____

Consent to Treat a Minor:_____ **Date:**_____

Guardian/Spouse's Signature of Authorizing Care:_____ **Date:**_____