

Is there anything you do that makes your condition worse? _____

How has this condition affected your life?

- A. Home life _____
- B. Occupational life _____
- C. Recreational life _____
- D. Rest and Sleep life _____

Have you ever been in an automobile accident? Past year Past 5 years Over 5 years Never
ANY ACCIDENTS, FALLS, ETC., THAT MIGHT HAVE CAUSED YOUR PROBLEM _____

What surgery has been done? _____

Are you pregnant? Yes No

DRUGS YOU NOW TAKE: Nerve Pills Pain Killers Muscle Relaxers "Pep" Pills Tranquilizers Insulin
 Birth Control Pills Other (please list) _____

ANY CHIROPRACTOR CONSULTED IN THE PAST? Name: _____

Dates consulted: _____ For what problem? _____

Fees are payable at the time X-rays, examinations, and treatments are received, unless other arrangements are made in advance. X-rays remain the property of this clinic.

Patient's Signature: _____ Social Security No. _____ Date _____

Your husband's/wife's Social Security No. _____

IF YOURS IS AN ACCIDENTAL INJURY, PLEASE COMPLETE THE FOLLOWING QUESTIONS

Date of accident: _____ Hour: ____ AM ____ PM Location: _____

How did accident occur? Auto Collision On-the-Job Injury Other _____

If not an auto collision, please describe the circumstances: _____

Did you report the injury to your foreman or employer? YES NO

Did he (they) recommend care at our office? YES NO

If auto accident, were you Driver? Passenger? Pedestrian?

If auto collision, were you struck from Behind? Right Side? Left Side? Front? Auto was parked

Did your car strike the other(s) involved? YES NO; Or did the other car strike yours? YES NO Undetermined

As a result of the accident, were traffic citations issued to you? YES NO; To the driver of the other car? YES NO

To the driver of your car? YES NO; List the extent of the injuries as you know them: _____

Did you require post-accident hospitalization? YES NO

CHECK SYMPTOMS YOU HAVE NOTICED SINCE ACCIDENT:

- | | | | | |
|--|---|--|--|--|
| <input type="checkbox"/> Headache | <input type="checkbox"/> Irritability | <input type="checkbox"/> Numbness in Toes | <input type="checkbox"/> Face Flushed | <input type="checkbox"/> Feet Cold |
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Buzzing in Ears | <input type="checkbox"/> Hands Cold |
| <input type="checkbox"/> Neck Stiff | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Loss of Balance | <input type="checkbox"/> Stomach Upset |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Head seems too heavy | <input type="checkbox"/> Depression | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Back Pain | <input type="checkbox"/> Pins & Needles in Arms | <input type="checkbox"/> Light bothers Eyes | <input type="checkbox"/> Loss of Smell | <input type="checkbox"/> Cold Sweats |
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Pins & Needles in Legs | <input type="checkbox"/> Loss of Memory | <input type="checkbox"/> Loss of Taste | <input type="checkbox"/> Fever |
| <input type="checkbox"/> Tension | <input type="checkbox"/> Numbness in Fingers | <input type="checkbox"/> Ears Ring | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> _____ |

Symptoms other than above: _____

Have you lost any days of work? YES NO Dates: _____

Name of Your Insurance Company Involved: _____

Name of Insurance Company of person responsible for injuries: _____

Have you been contacted by an Insurance Adjuster or Company Representative regarding this claim? YES NO

Do you have an attorney who has advised you in this case? YES NO Name: _____

Address of attorney: _____ Phone No: _____

Skocik Chiropractic P.C.
5431 Jonestown Rd.
Hbg., PA 17112

REVIEW OF SYSTEMS

Name: _____ Date: _____

The following information is geared toward finding any current or past health conditions which may affect or complicate your current condition or its treatment. Do you now have or have you had in the past, symptoms of or treatment for:

Eyes yes no Do you wear glasses or contacts yes no
Ears, Nose, Mouth, or Throat yes no
Gastrointestinal system yes no Do you have indigestion yes no
Pain after eating yes no Stomach cramps yes no
Genitourinary yes no
Have you ever had cancer yes no type: _____

For Men Do you get up and go to the bathroom frequently at night yes no
Have you ever been diagnosed with a prostate condition yes no
If yes enlarged prostate prostate cancer
Did you ever have prostate surgery yes no
If yes, when _____

For Women Do you have painful periods yes no
Do you have anemia yes no
Have you ever had a hysterectomy yes no
If yes, when _____
Did you have any C-Sections yes no
If yes, when _____
Have you been diagnosed with fibrocystic breast disease yes no
Have you ever had breast cancer yes no

Have you had any skin condition requiring treatment yes no
Have you ever had a stroke yes no
Do you have episodes where you feel dizzy yes no
Have you ever been treated for stress yes no
Do you have any hormonal conditions including:
Thyroid yes no Pancreas (diabetes or hypoglycemia) yes no
Any other _____
Do you have any blood conditions or disease yes no
If yes _____
Do you have any lymphatic system conditions or diseases yes no
If yes _____
Is there anything else you feel is important _____

Nearest relative _____ Phone _____

Signature _____

PATIENT NAME: _____

Please indicate beside each activity whether you engage in it:

OFTEN = "O"

SOMETIMES = "S"

NEVER = "N"

SOCIAL HISTORY

___ Horseback riding

___ Bowling

___ Golf

___ Volleyball

___ Baseball/softball

___ Handball

___ Racquetball

___ Basketball

___ Walking (mile or less)

___ Walking (more than mile)

___ Jogging (mile or less)

___ Jogging (more than mile)

___ Dancing

___ Scuba diving

___ Back packing

___ Swimming

___ Aerobics

___ Resistance training

___ Free weights

___ Exercise machines

___ Football

___ Tennis

___ Gymnastics

___ Skiing

___ Water skiing

___ Hunting

___ Fishing

___ Lawn mowing

___ Weed eater use

___ Snow shoveling

___ Gardening

___ Child care

Age(s) _____

Weight(s) _____

___ Climbing stairs

___ Alcohol _____ per day

___ Alcohol _____ per week

___ Medication _____

___ Tobacco _____

___ Other _____

FAMILY HISTORY

Please indicate if any of the following is currently or has contributed to some stress or personal lifestyle changes within the past five years.

___ Marriage

___ Birth of a child

___ Divorce

___ Death of spouse

___ Marital separation

___ Death of a family member or friend

___ Handicapped household member

___ Caregiver to family member

___ Spousal abuse

___ Dependence problems

___ Alcohol

___ Drugs

___ Change in job

___ Loss of job

___ Retirement

___ Change in living conditions

___ Change in residence

___ Change in financial status

Insurance Questionnaire

The following questions are necessary to properly file you insurance claims.

Patient's Name

Patient's Date of Birth

Primary Insurance:

Insurance Company Name

Subscriber's Name

Subscriber's Employer

Subscriber's Date of Birth

Patient's Relationship to Subscriber: Self Spouse Child Other

Other Insurance:

Insurance Company Name

Subscriber's Name

Subscriber's Employer

Subscriber's Date of Birth

Patient's Relationship to Subscriber: Self Spouse Child Other

Medicare Only:

All doctors have been instructed to ask the following questions of all Medicare patients.
Please circle either Yes or No

1. Do you or your spouse work for a company that provides you with health insurance? **Yes No**
2. Are you entitled to Medicare because of End Stage Renal Disease? **Yes No**
3. Is this illness or injury the result of an accident or other injury? **Yes No**
4. Is this illness or injury the result of an accident or other injury that happened at work? **Yes No**
5. Has the treatment of this accident or illness been authorized by the Veteran's Administration?
Yes No
6. Are you entitled to any benefits under the Federal Black Lung Program? **Yes No**
7. Do you have a Medicare Medigap Policy? **Yes No**
8. Do you have a Medicare Supplemental Policy? (Policy provided by the Employer you retired from)
Yes No

Patient or Guardian Signature

Date

Skocik Chiropractic
5431 Jonestown Rd.
Harrisburg, PA 17112

Name: _____ Date: _____

How were you referred to our office?

- Patriot News
- The Guide
- East Shore Shopper
- Parent Magazine
- Attorney Referral
- Doctor Referral
- Friend / Relative Name: _____
- Mailer
- Radio
- Sign and/or Location
- Spinal Screening Location: _____
- Television
- Verizon
- Yellow Book
- Previous Patient
- Other: _____

SKOCIK CHIROPRACTIC

**5431 Old Jonestown Road
Harrisburg, PA 17112**

Welcome to Skocik Chiropractic. We wish to assist you in gaining and maintaining your good health.

Accordingly we offer you a complimentary preliminary spinal examination and a report of our findings. The preliminary examination consists of a neurologic test, a spiral alignment check, a muscle test, a blood pressure test and may include an orthopedic test. The report will immediately follow the preliminary exam and at that time you may decide if you would like to proceed with a Chiropractic evaluation.

This is a screening examination only. It will be likely you will need a more in-depth examination, it may be necessary for you to have x-rays, therapies, or other testing, treatment, or supports. If these services are necessary, there will be a charge for them. If you have health insurance, we will be happy to bill them for you. Please provide the receptionist with your health insurance information.

Signature

Date

Slocik Chiropractic P.C.
5431 Jonestown Rd.
Hbg., PA 17112
(717) 540 8448
fax (717) 540 6233

Consent for use or Disclosure of Health Information / Appointment Reminders / Ongoing Communication

Our Privacy Pledge

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to use or disclose your health care information.

- We may have to disclose your health information to another health care provider or a hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition
- We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.
- We may need to use your health information within our practice for quality control or other operational purposes.

Your chiropractor and members of the practice staff may need to use your name, address, phone number and your clinical records to contact you with appointment reminders, information about treatment alternatives, or other health related information that may be of interest to you. If this contact is made by phone and your not home a message will be left on your answering machine. By signing this form, you are giving authorization to contact you with these reminders and information.

Your chiropractors and members of the practice staff may use your health information including your name, address, phone number and your clinical records for the purposes listed below. We are specifically requesting authorization to market the following products and/or services to you:

1. Birthday and holiday cards
2. Flowers on certain occasions
3. Patient newsletters
4. Posting names for referring others
5. Displaying testimonials and photographs with your implied permission, by filling out the testimonial
6. Electronic mail newsletters (if applicable) and E-Mail

We have a more complete notice that provides a detailed description of how your health information may be used or disclosed. You have the right to review that notice before your sign this consent form (§164.520 and 164.524). We reserve the right to change our privacy practices as described in that notice. If we make a change to our privacy practices, we will notify you in writing when you come in for treatment or by mail. Please feel free to call us at any time for a copy of our privacy notices.

Your right to limit uses or disclosures

You have the right to request that we do not disclose your health information to specific individuals, companies, or organizations. If you would like to place any restrictions on the use or disclosure of your health information, please lets us know in writing. We are not required to agree to your restrictions. However, if we agree with your restrictions, the restriction is binding on us.

Your right to revoke your authorization

You make revoke your consent to us at any time; however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we received your request to revoke your authorization. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have a right to your health information if they decide to contest any of your claims.

I have read your consent policy and agree to it terms. I am also acknowledging that I have received a copy of this notice.

Printed Name

Authorized Provider Representative

Signature

Date

Date

Form 10/04