APPLICATION FOR TREATMENT

Date _____

Name: _____ Age: _____ Date of Birth: _____
Address: _____City _____ State _____ ZIP _____
Phone: Home _____ Work _____ Cell _____
Email: _____ Preferred method for appointment reminders: [] Email []Phone [] Mail
Marital Status: [] Married [] Single [] Widowed [] Divorced [] Separated Gender: [] Male [] Female
SS#: _____ If a minor Parent/Guardian SS#: _____
Who is responsible for your bill? [] Self [] Workers Comp [] Auto Ins [] Health Ins [] Other_____
If female: Are you or do you suspect you may be pregnant? [] Yes [] No
Employer: _____ Preferred Language: _____
Smoking Status: [] Every day Smoker [] Occasional Smoker [] Former Smoker [] Never Smoked
Please describe the principal health problems for which you came to this office. _____
_____
How and when did symptoms first occur? _____
Rate the level of severity of your current problem. (Circle One) Not Severe 1 2 3 4 5 Very Severe
Are you currently treating with another doctor for this condition? [] Yes [] No
List any doctors previously seen or currently treating for this condition _____
List diagnosis(es) and type of treatment(s) _____
_____
Does this interfere with your normal living and work? [] Yes [] No In what way? _____
Have you lost any days of work? [] Yes [] No Dates _____
Have you had similar symptoms or injuries before? [] Yes [] No If yes, explain _____
_____
List the names of any relatives that have or have had a similar problem _____

CMS requires providers to report both race and ethnicity

Race: [] American Indian or Alaska Native [] Asian [] Black or African American [] White (Caucasian)
[] Native Hawaiian or Pacific Islander [] Other [] I Decline to Answer

Ethnicity: [] Hispanic or Latino [] Not Hispanic or Latino [] I Decline to Answer

Are you currently taking any medication? (Please include regularly used over the counter medications)

Medication Name	Dosage and Frequency (i.e. 5mg, once a day)

Do you have any medication allergies?

Medication Name	Reaction	Onset Date	Additional Comments

FAMILY HISTORY

Name of wife or husband _____ Ages of children _____
Spouse's Employer _____ Business Phone _____
Your Nearest Relative _____
Relative's Address _____ Phone _____

PAST HISTORY

Has a physician treated you for any health condition in the last year? [] Yes [] No If yes, explain: _____

_____

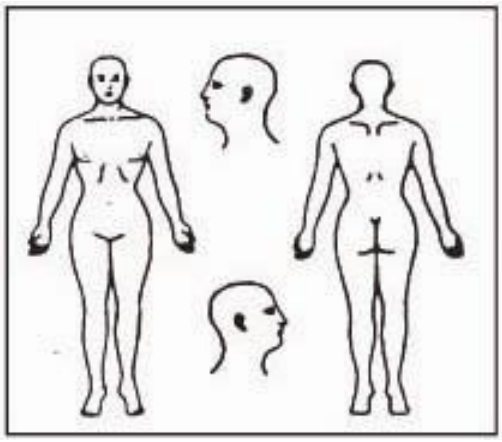
Have you or any relative received Chiropractic treatment previously? [] Yes [] No If yes, for what condition(s)_____

_____

How would you rate your experience: Poor 1 2 3 4 5 Excellent

List the approximate dates of any operations, unusual diseases, serious illnesses or accidents you have had (include any broken bones) _____

Please mark your areas of pain on the figures below.



List the conditions that you are most interested in getting corrected. List in order of importance:

1. _____
2. _____
3. _____
4. _____

What functions are you unable to perform or induce pain upon performance? List in order of severity. (Example: sitting, walking, bending, lying down, etc.)

1. _____
2. _____
3. _____
4. _____

In compliance with requirements for the government EHR incentive program.

[] I choose to decline receipt of my clinical summary after every visit. (These summaries are often blank as a result of the nature and frequency of chiropractic care.)

Patient Signature: _____ Date: _____

I hereby give permission for treatment.

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.
I HEREBY GIVE PERMISSION FOR TREATMENT.

_____	_____	_____
Patient/ Guardian Signature	Patient/ Guardian SS#	Date

If this condition is related to a Worker's Compensation or Automobile Accident please complete the following questions:

How did the injury occur? [] Auto Collision [] On-the-Job Injury [] Other_____

Date of Accident: _____ Hour: _____ AM / PM Location: _____State: _____

Did you report the injury? [] Yes [] No Did he/she recommend treatment in our office? [] Yes [] No

Insurance Carrier Name: _____ Phone: _____Claim #: _____

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: _____

Attorney's Address: _____ Phone: _____

For office use only

Height:_____ Weight:_____ Blood Pressure: _____

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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below I acknowledge that I have received a copy of Skocik Chiropractic, PC Notice of Privacy Practices.

_____ _____
Print Patient Name Patient Date of Birth

_____ _____
Signature of patient or personal representative Date

_____
If signed by personal representative, relationship to patient

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Office Use Only:

Our organization has made a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual named below.

Patient Name: _____

Refused to sign ( ) Physically unable to sign ( )

(Other) _____
_____
_____
_____

_____ _____
Employee Signature Date

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 then mile)
____ Jogging (mile or less)
____ Jogging (more than mile)
____ Dancing
____ Scuba diving
____ Back packing
____ Swimming
____ Aerobics
____ Resistance Training
____ Free weights

____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 with in the past five years.

___ Marriage
___Birth of 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