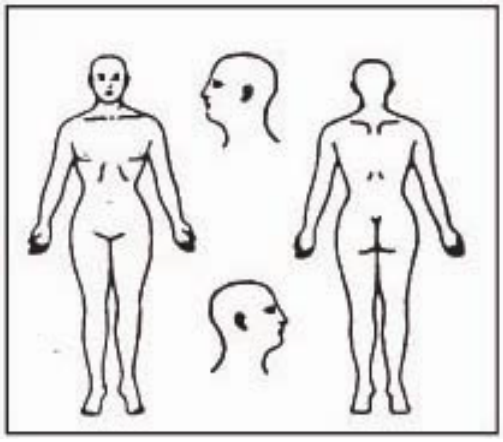
APPLICATION FOR TREATMENT

Today's Date _____

Name: _____ Age: _____ Date of Birth: _____
Address: _____City _____ State _____ ZIP _____
Phone: Home _____ Work _____ Cell _____
Email: _____ Preferred method for appointment reminders: [] Email [] Phone [] Mail [] Text
Marital Status: [] Married [] Single [] Widowed [] Divorced [] Separated Gender: [] Male [] Female
SS#: _____ If a minor Parent/Guardian SS#: _____
Employer: _____ Preferred Language: _____

CURRENT CONDITION

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 _____
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. _____

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

EMERCENCY CONTACT

Name of spouse or partner _____ Ages of children _____
Spouse's Employer _____ Business Phone _____
Nearest Relative's Name _____ Relationship _____
Relative's Address _____ Phone _____

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

INSURANCE QUESTIONNAIRE

Who is responsible for your bill? [] Self [] Workers Comp [] Auto Ins [] Health Ins [] Other_____

Health Insurance ONLY

Primary Insurance:

Insurance Company Name: _____ Subscriber's Employer: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Patient's Relationship to Subscriber: Self Spouse Child Other

Other Insurance:

Insurance Company Name: _____ Subscriber's Employer: _____
Subscriber's Name: _____ Subscriber's Date of Birth: _____
Patient's Relationship to Subscriber: Self Spouse Child Other

Worker's Compensation, Automobile Accident or Personal Injury ONLY

How did the injury occur? [] Auto Accident [] Worker's Comp Injury [] Other _____
Date of Accident: _____ Time: _____ 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 #: _____
Address: _____City: _____ State: _____ ZIP: _____
Have you been contacted by an Insurance Claims Adjuster? [] Yes [] No Adjuster Name: _____
Do you have an attorney? [] Yes [] No Name: _____Phone: _____
Address: _____City: _____ State: _____ ZIP: _____

Skocik Chiropractic P.C.
5431 Jonestown Road
Harrisburg, 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	Do you have indigestion	( ) yes ( ) no
Gastroinestinal system	( ) yes ( ) no	Stomach Cramps	( ) yes ( ) no
Pain after eating	( ) yes ( ) no		
Genitourinary	( ) yes ( ) no		
Have you ever has 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
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
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 a mile)
___Jogging (mile or less)
___Jogging (more than a mile)
___Dancing
___Scuba diving
___Back packing
___Swimming
___Aerobics
___Resistance training
___Free weight
___Exercise 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 a spouse
___Marital separation
___Death of a family member or friend
___Handicapped household member
___Caregiver to family member
___Spousal abuse
___Dependence problems
___Alcohol
___Drug
___Change in job
___Loss of job
___Retirement
___Change in living conditions
___Change in residence
___Change in financial status

Skocik Chiropractic

Patient HIPAA Acknowledgement and Designation Disclosure Form

Patient Name: _____ Date of Birth: _____

1. **Acknowledgement of Practice's Notice of Privacy Practices:**
   By signing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

   _____ _____
   Signature of Patient/Parent/Guardian Date

2. **Designation of Certain Relatives, Close Friends, and other Caregivers as a Personal Representative:**
   I agree that the practice may disclose certain pieces of my health information to a Personal Representative of my choosing since such person is involved with my healthcare or payment relating to my healthcare. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my healthcare or payment relating to my healthcare.

   Name: _____ Relationship: _____ Date of Birth: _____
   Name: _____ Relationship: _____ Date of Birth: _____
   Name: _____ Relationship: _____ Date of Birth: _____

Office Use Only:

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

Patient Name: _____

Refused to sign ( ) Physically unable to sign ( )
(Other) _____
_____
_____

_____ _____
Employee Signature Date