Active Family and Sports Chiropractic

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Date: _____/_____/_____Patient's Full Name: _____
Home Phone: _____ Cell Phone: _____ Work : _____
☐Male ☐Female Age: ___ Date of Birth: ___/___/____Social Security #: ____ - ____ - _____
Address: _____ City: _____ State: ___ Zip: _____
E-Mail: _____
☐Married ☐Single ☐Widowed ☐Separated ☐Divorced Number of Children: ___ Ages: ____
Occupation: _____Employer: _____
Emergency Contact: _____ Relationship: _____
Phone: _____ City: _____ State: ____
Whom may we thank for this referral? _____
Family Physician: _____Address: _____
City: _____ State: ___ Zip: _____Phone:_____
May our office inform your physician of our exam findings, diagnosis, and treatment plan?
☐Yes ☐No

Insurance Information
Primary Insurance Company: _____Subscriber's Name: _____
ID#: _____ Group#: _____ Subscriber's DOB: ___/___/____
Secondary Insurance Company: _____ Subscriber's Name: _____
ID#: _____ Group#: _____ Subscriber's DOB: ___/___/____

Work or Auto Accident Information
Is injury work or auto related? ☐Yes ☐No Date of injury: __/__/__ Injury reported? ☐Yes ☐No
Claim #: _____ Adjuster Name/Phone #: _____
Name/Address /Phone of Insurance: _____
Name/Address/Phone of Attorney: _____

Chief Complaint
Chief complaint: _____
Secondary or related complaint(s) if any: _____
Was the Onset: ☐Gradual ☐Sudden Since the onset, has it gotten: ☐Worse ☐Better
When did it first occur? _____ Has this occurred before: ☐Yes (Describe: _____) ☐No
Describe what caused the pain: _____
What does your condition prevent you from normally doing? ☐sitting/driving ☐walking
☐running ☐golfing ☐swimming ☐weight lifting ☐playing with children
☐normal activities of daily living ☐other: _____
What is your long-term goal from treatment (e.g. play a round of golf without pain)?
_____
_____

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Describe the quality of the complaint:
- ☐ sharp
- ☐ dull/ache
- ☐ throbbing
- ☐ tingling/numbness
- ☐ burning
- ☐ other: _____

Describe the location of the symptoms:
- ☐ radiating dull, deep ache
- ☐ pin point
- ☐ pain starts localized, then radiates
  Describe: _____
- ☐ other: _____

The symptoms are:
- ☐ more prevalent in the morning
- ☐ more prevalent at night
- ☐ better as the day goes on
- ☐ worse as the day goes on

How often are you aware of the symptoms:
- ☐ intermittent (less than 25% of time)
- ☐ occasional (25-50% of time)
- ☐ frequent (50-75% of time)
- ☐ constant (75-100% of time)

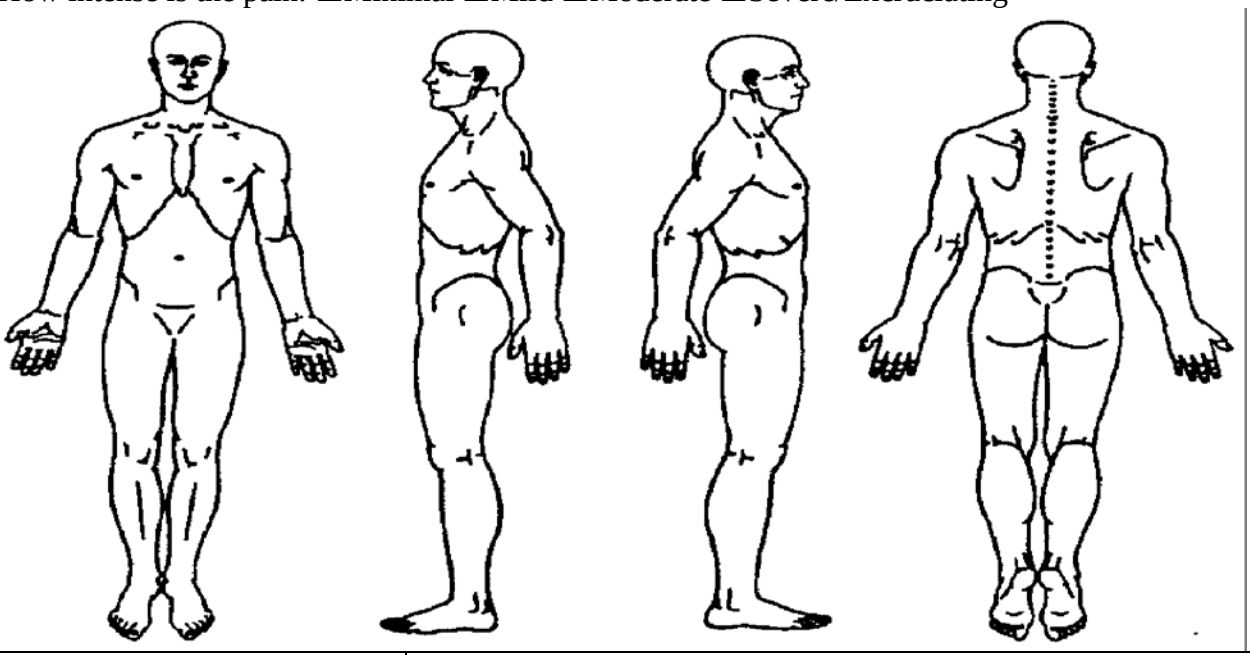
Do any of the following make the pain worse:
- ☐ lifting/pushing/pulling
- ☐ cough/sneeze/bowel movement
- ☐ driving/riding/sitting
- ☐ walking/running/standing
- ☐ bending forward/leaning back
- ☐ other:_____

Does any of the following make it better:
- ☐ rest/laying down
- ☐ sitting
- ☐ walking/exercise
- ☐ standing
- ☐ other:_____

The symptoms feel:
- ☐ better with exercise/activity
- ☐ worse with exercise/activity
- ☐ no change with exercise/activity

Does it interfere with your daily activities:
- ☐ minimal (annoyance, no impairment)
- ☐ slight (tolerated, some impairment)
- ☐ moderate (marked impairment)
- ☐ marked (preclude any activity)

How intense is the pain: ☐Minimal ☐Mild ☐Moderate ☐Severe/Excruciating



Pain Scale
0 1 2 3 4 5 6 7 8 9 10
←————————————→
Please indicate pain level 0-10

Use the following letters to indicate the type and location of discomfort:

A – Aching
B – Burning
N - Numbness/Tingling
P - Pins and Needles
S - Stabbing/Sharp
T - Throbbing
O - Other

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Have you had any changes in bowel or bladder functioning? ☐Yes ☐No
What medications are you currently taking? _____
What vitamins/supplements are you currently taking?_____
Females only: Are you currently pregnant? ☐Yes ☐No
In general, would you say your health is: ☐Excellent ☐Very good ☐Good ☐Fair ☐Poor
Would you be interested in any other services that may help your condition or improve your overall health? ☐Vitamins/supplements ☐Rehabilitation ☐Orthotics ☐Exercise
Previous Chiropractic Care: ☐Yes ☐No If Yes, for what Problem:_____
What treatment(s) were received: _____
Were they helpful? ☐Yes ☐No
Doctor's Name: _____ Address: _____
City: _____ State: _____ Zip: _____ Phone: _____

PAST HEALTH HISTORY

Have you been treated for your present problem in the past? ☐Yes ☐No
If yes, when: _____ If yes, by whom: _____ Outcome:_____

Please list any major illnesses, injuries, broken bones, hospitalizations, accidents, or surgeries.

Date	Injury/Fracture/Illness/Surgeries	Treatment	Results

Please indicate any of the following illnesses you have had or currently have with approximate dates.

High Blood Pressure_____ Prostate disease_____
Multiple Sclerosis_____ Heart disease_____
Ulcer_____ Stroke_____
Allergies_____ Cancer_____
Diabetes_____ Scoliosis_____
Serious injury/fall_____ Kidney disease_____
Mental/Emotional_____ Auto accident_____
HIV_____ Seizures_____
Other_____

Signature of Patient: _____
Date:_____

Patient Informed Consent for Treatment

I _____ do hereby give my consent to the performance of Chiropractic treatment. I understand that the procedures may consist of manipulations/adjustments involving movement of the joints and soft tissues and physiotherapies and exercises may also be used. I consent to the performance of examinations and testing for proper diagnosis and treatment.

I have disclosed all of my past medical history to Dr. Glogowski so that an appropriate treatment plan can be developed. I am aware of the risks associated with my treatment, the most common of which is soreness in the treated area, and fully and freely accept those risks. I will report any soreness or discomfort that I feel, from the treatment or otherwise, promptly to Dr. Glogowski.

Any questions I have had regarding these treatment procedures, treatment results or treatment alternatives have been answered to my satisfaction PRIOR TO MY SIGNING THIS CONSENT FORM. I have made my decision voluntarily and freely.

Patient's Signature _____Date_____

Witness's Signature _____Date_____

Notice of Privacy Policy for Protected Health Information

THIS NOTICE DESCRIBES HOW CHIROPRACTIC AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW THIS FORM CAREFULLY AND LET US KNOW IF YOU HAVE ANY QUESTIONS. A COPY OF THIS FORM WILL BE GIVEN TO YOU UPON YOUR REQUEST.

Our Duties

We are required by law to maintain the privacy of your health information. We are also required to provide you with this notice of our legal duties and our privacy practices with respect to your health information.

Privacy Pledge

We respect our patients' right to privacy and value your trust. We will never provide your contact or health information to any outside organization for marketing or solicitation. In general, we will not disclose your protected health information without your prior written consent. Some exceptions are listed below.

Uses and Disclosures for Which Your Consent is Requested

1) Disclosure to another health care provider for referrals for treatment _____ (initial)
2) Disclosure to third party billing, insurance carrier for payment of services _____ (initial)
3) Disclosure to contact your for appointment reminders _____ (initial)
   May we leave a message on your voicemail? YES/NO

I consent to the above listed disclosures which I have initialed and I understand that I have the right to revoke this consent, in writing, at any time.

Signature_____ Date_____

Permitted Uses and Disclosures Without Your Consent

Under federal law, we are permitted to use or disclose your health information without your consent in the following circumstances:

1) If we provide health care services to you based on the orders of another health care provider
2) If we provide health care services to you as an inmate
3) If we provide health care services to you in an emergency
4) If we are required by law to treat you and we are unable to obtain your consent prior to doing so
5) If there are substantial barriers to communicating with you, but in our professional judgment we believe that you intend for us to provide care
6) If we have reasonable cause to suspect that a child has been abused
7) If you disclose to us your intent to harm another person

Your Right to Inspect and Copy Your Health Information

You have the right to inspect and/or copy our health information for seven years form the date that the record was created or as long as the information remains in our files. We require that your request to inspect and/or copy your record be made in writing.

Your Right to Amend Your Health Information

You have the right to request that we amend your health information for seven years from the date that the record was created or as long as the information remains in our files. We require that your request to amend your health information be made in writing and that you give us a reason to support the change that you are requesting us to make.

Your Right to Receive an accounting of the Disclosures We Have Made of Your Record

You have a right to request that we give you an accounting of the disclosures we have made of your record for the last seven years before the date of your request.

Re-Disclosure

Information that we use or disclose may be subject to re-disclosure by the person to whom we provide the information and may no longer be protected by the federal privacy rules.

Your Right to Complain

You may complain to us or to the Secretary of Health and Human Services is you feel that we have violated your privacy rights. We respect your right to file a complaint and will not take action against you if you do so.

(TURN OVER)

Emergency Contact

We request that you provide us with the name and contact information for a person whom you would like to designate as an emergency contact. By providing the name and contact information for that person, you are authorizing us to speak to the designated person and to use or disclose your health information to that person. You may change your designated emergency contact, by written notification to us, at any time.

Name of Emergency Contact_____

Contact phone number: Home _____ Cell_____

This notice is effective as of December 30, 2011. This notice will expire seven years after the date upon which the record was created. By signing below, I acknowledge that I have read and understood this notice and that I consent to the privacy policy of Active Family and Sports Chiropractic.

_____ _____

Patient Name Printed Date

_____

Patient Signature

_____ _____

Witness Signature Date