

# PATIENT INFORMATION

PLEASE ALLOW OUR STAFF TO PHOTOCOPY YOUR DRIVER'S LICENSE & ALL INSURANCE CARDS

## PLEASE PRINT

Name \_\_\_\_\_ birth date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ PA \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone # \_\_\_\_\_ E-Mail \_\_\_\_\_

Age \_\_\_\_\_ SS# \_\_\_\_\_ Marital Status S M W D # Children \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Health Insurance Co. \_\_\_\_\_ ID# \_\_\_\_\_

Group ID# \_\_\_\_\_

Name of Spouse, Parent or Guardian \_\_\_\_\_

How did you find out about our office \_\_\_\_\_

Describe the major complaints that brought you to our office: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Is your condition due to an accident?  Yes  No Date of accident: \_\_\_\_\_

\_\_\_\_\_

I (we) agree to pay for services rendered to the above-mentioned patient as the charge is incurred. I (we) understand that health and accident insurance policies are arrangements between an insurance carrier and myself and that I am personally responsible for payment of any and all services, covered or noncovered. If the doctor is a contracted provider for my managed care plan, I understand I am responsible for all copayments and non-covered services. I also understand and agree to pay all copays and fees for non-covered services prior to seeing the doctor. I understand that if I terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable. I understand that unpaid fees for services beyond thirty (30) days are subject to a 1.5% monthly finance charge (18% annually).

I (we) authorize the doctor and his staff to release any information deemed appropriate concerning my physical condition to any insurance company, claims adjuster, case nurse, claims reviewer, employer, health care provider or attorney in order to process any claim for reimbursement or charges incurred by me as a result of professional services rendered and hereby release him/her of any consequences thereof. I agree that a photostatic copy of this agreement shall serve as the original.

I (we) hereby authorize and direct payment of any medical/chiropractic expense benefits allowable to the doctor as payment toward the total charges for professional services rendered. This payment will not exceed my indebtedness to the assignee. I agree that a photostatic copy of this agreement shall serve as the original.

Patient's Signature \_\_\_\_\_ date \_\_\_\_\_

Spouse's/Guardian's Signature \_\_\_\_\_ date \_\_\_\_\_

# CASE HISTORY

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Please answer the questions below concerning your health history. Be sure to list all conditions or symptoms, both past and present.

**An understanding of your health history will help us to determine appropriate care.**

Full Name \_\_\_\_\_ date \_\_\_\_\_

Age: \_\_\_\_\_ Race: \_\_\_\_\_ Gender \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_

## **Review of Symptoms**

1. Do you have skin, hair or nail problems. Yes No \_\_\_\_\_
  2. Do you have mouth and/or throat problems Yes No \_\_\_\_\_
  3. Do you have nose and/or sinus problems Yes No \_\_\_\_\_
  4. Do you have ear problems Yes No \_\_\_\_\_
  5. Do you have eye problems Yes No \_\_\_\_\_
  6. Do you have chest or lung (breathing) problems Yes No \_\_\_\_\_
  7. Do you smoke Yes No Cigarettes per day \_\_\_\_\_ How long \_\_\_\_\_
  8. Do you have heart and/or blood vessel problems Yes No \_\_\_\_\_
  9. Do you have blood or lymph node problems Yes No \_\_\_\_\_
  10. Do you have digestive problems Yes No \_\_\_\_\_
  11. Do you have genital problems (e.g., prostate, testicular, vaginal) Yes No \_\_\_\_\_
  12. Do you have urinary (including kidney or bladder) problems Yes No \_\_\_\_\_
  13. **Females**, have you had menstrual problems Yes No \_\_\_\_\_  
Have you ever taken birth control pills Yes No \_\_\_\_\_  
Is there any chance that you are currently pregnant Yes No \_\_\_\_\_  
Do you have any breast problems Yes No \_\_\_\_\_
  14. Do you have any nervous system diseases and/or mental health problems Yes No \_\_\_\_\_

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  15. Do you have any gland and/or hormone problems Yes No \_\_\_\_\_
  16. Do you have allergy or immunity problems Yes No \_\_\_\_\_
  17. Do you have any muscle, tendon or ligament problems Yes No \_\_\_\_\_
  18. Do you have any bone or joint diseases (e.g., bone-osteoporosis, joint-arthritis) Yes No \_\_\_\_\_
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**Past History**

19. List any diseases that you have had in the past, including childhood diseases: \_\_\_\_\_  
\_\_\_\_\_
20. Tell us if you have ever been diagnosed as having a particular condition such as diabetes, cancer, AIDS, etc.,  
\_\_\_\_\_
21. Have you suffered any physical injuries, such as falls or blows, automobile accidents, whiplash, concussion or head injury, lacerations, sprains, strains, dislocations, broken or cracked bones Yes No \_\_\_\_\_  
\_\_\_\_\_
22. List any surgeries you have had (e.g., appendix, tonsils, ear tubes, wisdom teeth):  
\_\_\_\_\_ date \_\_\_\_\_  
\_\_\_\_\_ date \_\_\_\_\_  
\_\_\_\_\_ date \_\_\_\_\_
23. Have you ever been hospitalized for any reason other than surgery Yes No \_\_\_\_\_  
\_\_\_\_\_

**Medications**

24. Please list all medications (prescription and nonprescription) you are currently taking or take on an occasional basis: \_\_\_\_\_
25. Your diet is:                      Balanced                      Poor                      Excessive                      Restricted

**Family History**

26. Are there any diseases or conditions that are common among your family members (i.e., inherited diseases or conditions) Yes No \_\_\_\_\_

**Social History**

27. In what position do you usually sleep, and how well \_\_\_\_\_  
\_\_\_\_\_
28. Do you exercise on a regular basis Yes No How \_\_\_\_\_
29. How do you spend your spare time (hobbies, etc.,) \_\_\_\_\_
30. Do you use                      Caffeine    Tobacco    Nicotine                      Recreational drugs    Alcohol
31. Please describe your work.  
Type: Professional    Physical Labor                      Driver                      Clerical                      Factory                      Homemaker  
Physical Demands: Heavy                      Moderate                      Mild                      Sedentary

Stress Level:            High            Medium            Low

**Additional Questions**

32. Do you have problems with recurrent headaches            Yes            No
33. Are you losing weight without trying            Yes            No
34. Does your pain wake you up at night            Yes            No
35. Have you had a change in bowel or bladder habits            Yes            No
36. Have you had a sore that doesn't heal            Yes            No
37. Have you recently had any unusual bleeding or discharge            Yes            No
38. Do you have a thickening/lump in the breast or elsewhere            Yes    No    \_\_\_\_\_
39. Do you have indigestion or difficulty swallowing    Yes    No    \_\_\_\_\_
40. Have you had an obvious change in a wart or mole            Yes    No    \_\_\_\_\_
41. Do you have a nagging cough or hoarseness    Yes    No    \_\_\_\_\_
42. In the space below, please explain or give additional details regarding the information you have given above. Also, if there is any information about your health history that was not requested, please fill it in below.
43. Please describe your current complaint. In other words, what brought you here. \_\_\_\_\_  
\_\_\_\_\_
44. Who is your:  
Medical doctor: \_\_\_\_\_  
OB/GYN \_\_\_\_\_  
Dentist \_\_\_\_\_

## SYSTEM/SYMPTOM REVIEW

			Stroke (full or pin)	Y	N
Do you currently have any of the following					
<b>Integument System</b>					
Skin Rash	Y	N	Dizziness	Y	N
Skin Lesion	Y	N	Cool hands or feet	Y	N
Changes in skin color	Y	N	Varicose veins	Y	N
Itching (pruritus)	Y	N	Mitral valve problems	Y	N
Hair Changes	Y	N	<b>Pulmonary System</b>		
Nail Changes	Y	N	Coughing	Y	N
<b>Digestive System</b>			Phlegm/expectorant	Y	N
Abdominal pain	Y	N	Coughing up blood	Y	N
Nausea	Y	N	Shortness of breath	Y	N
Vomiting	Y	N	Wheezing	Y	N
Constipation	Y	N	Blue Skin (cyanosis)	Y	N
Diarrhea	Y	N	Chest pain	Y	N
Rectal bleeding	Y	N	<b>Nervous System</b>		
Jaundice	Y	N	Partial paralysis	Y	N
Abdominal distention	Y	N	Complete paralysis	Y	N
Cramping	Y	N	Headache	Y	N
Lump/mass	Y	N	Are you right handed	Y	N
<b>Cardiovascular System</b>			Loss of consciousness	Y	N
Chest pain	Y	N	Dizziness	Y	N
Irregular heartbeat	Y	N	Memory loss	Y	N
Fainting	Y	N	Numbness	Y	N
Fatigue	Y	N	Weakness	Y	N
Swelling of legs	Y	N	Depression	Y	N
Changes in skin color	Y	N	Lack of coordination	Y	N
			Psychiatric disorders	Y	N

Speech Abnormalities	Y	N
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**Nervous System (Continued)**

Visual disturbances	Y	N
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Are you left handed	Y	N
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Gait disorders	Y	N
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Tremors	Y	N
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Tics (spasms)	Y	N
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Sensory changes	Y	N
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Mood changes	Y	N
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**Endocrine System**

Hormone problems	Y	N
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Hot flashes	Y	N
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Thyroid problems	Y	N
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Hormone therapy	Y	N
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Growth abnormalities	Y	N
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Metabolism changes	Y	N
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**Musculoskeletal System**

Stiffness	Y	N
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Popping noises	Y	N
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Joint pain	Y	N
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Weakness	Y	N
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Limitation of movement	Y	N
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Extremity deformities	Y	N
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Difficulty walking	Y	N
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**Genital/Urinary System**

Pain during urination	Y	N
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Changes in urine flow	Y	N
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Lump or mass in groin	Y	N
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Kidney stones	Y	N
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Chronic bladder infections	Y	N
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Genital itching	Y	N
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Changes in urination frequency	Y	N
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Change in urine color	Y	N
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**Reproductive System**

**Male Only**

Testicular pain	Y	N
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Prostate problems	Y	N
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Infertility	Y	N
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Impotence	Y	N
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Discharge	Y	N
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Lump or mass	Y	N
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**Female Only**

Abnormal vaginal bleeding	Y	N
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Painful menstruation	Y	N
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Breast lump/mass	Y	N
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Vaginal discharge/itching	Y	N
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Nipple discharge	Y	N
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Infertility	Y	N
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Abnormal periods	Y	N
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Male pattern baldness	Y	N
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**Head and Neck Region**

Headaches	Y	N
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Neck stiffness	Y	N
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Neck lump/mass	Y	N
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Eye pain	Y	N
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Eye redness	Y	N
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Eye discharge	Y	N
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Double vision	Y	N
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Dry eyes	Y	N
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Excessive tearing	Y	N
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**Head and Neck Region (continued)**

Spinning sensation	Y	N
Ringing in ears	Y	N
Ear pain	Y	N
Ear discharge	Y	N
Ear itching	Y	N
Nasal discharge	Y	N
Sinus trouble	Y	N
Bad breath	Y	N
Nasal Obstruction	Y	N
Snoring	Y	N

**Blood, Lymphatics, Immunology, Allergy**

Anemia	Y	N
Iron deficiency	Y	N
Clotting problems	Y	N
Bruise easily	Y	N
Swollen lymph nodes	Y	N
Frequent illness	Y	N
Immunity problems	Y	N
Allergies	Y	N
Take allergy shots	Y	N

**Special Senses**

Visual problems	Y	N
Hearing loss	Y	N
Loss of balance	Y	N
Loss of taste	Y	N
Loss of smell	Y	N

Loss of touch sensation	Y	N
Temporary vision loss in 1 eye	Y	N

**Have you ever (at any time) experienced any of the following**

Difficulty urinating	Y	N
Loss of bladder control	Y	N
Loss of bowel control	Y	N
Temporary loss of vision	Y	N
Blood in urine	Y	N
Claustrophobia	Y	N
Spinal surgery	Y	N
Carotid artery surgery	Y	N
Breast removal	Y	N

**Have you every been diagnosed with/told you have one of the following**

Detached retina	Y	N
Stroke	Y	N
Slipped disc	Y	N
Herniated disc	Y	N
Osteoporosis	Y	N
TIAs (ministroke)	Y	N
Drop attacks (collapsing)	Y	N
Hardening of arteries	Y	N
Partial or complete paralysis	Y	N
Rheumatoid arthritis	Y	N
Fracture/broken vertebra	Y	N
Bleeding disorders	Y	N
High blood pressure	Y	N
Blood in stool	Y	N
Cancer	Y	N
AIDS	Y	N

Kidney disease	Y	N	Body piercing	Y	N
Prostate disease	Y	N	Tattoos	Y	N

**Do you currently have or could you be, any of the following**

Pregnant	Y	N
Taking birth control pills	Y	N
Receiving hormone therapy Male female	Y	N
Receiving chemotherapy	Y	N
Receiving radiation therapy	Y	N
Taking blood thinners	Y	N
A heavy smoker	Y	N

Surgical/medical implanted devices

Aortic clips	Y	N
Brain clips	Y	N
Artificial heart valves	Y	N
Rods, pins, screws	Y	N
IUD	Y	N
Surgical clips/wires	Y	N
Shunt	Y	N
Neurostimulator	Y	N
Dentures	Y	N
Pacemaker	Y	N
Hearing aid	Y	N
Insulin pump	Y	N
Joint replacement	Y	N
Cochlear implants	Y	N

Other implanted devices:

Metal fragments	Y	N
Bullets/shrapnel	Y	N

**In the past 14 days, have you experienced any of the following**

Nausea	Y	N
Vomiting	Y	N
Vertigo	Y	N
Difficulty walking	Y	N
Incoordination	Y	N
Numbness	Y	N
Loss of consciousness	Y	N
Double vision	Y	N
Blurred vision	Y	N
Tinnitus (ringing in ears)	Y	N
Speech problems	Y	N
Clumsiness	Y	N
Memory loss	Y	N
Travel by car/truck	Y	N
Personality changes	Y	N
Fever	Y	N
Recurrent headaches	Y	N
Diarrhea	Y	N
Used a tanning bed/booth	Y	N
Skin rash/infection	Y	N
A major fall	Y	N
A minor fall	Y	N
Auto accident	Y	N
Work injury	Y	N
Loss of strength	Y	N

Pain during bowel movement    Y    N

Abnormal period                    Y    N

Head trauma                        Y    N

**Doctor's Notes**

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# CONSENT FORM

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 is rendered me and charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered me will be immediately due and payable.

I hereby authorize the Doctor to examine and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

I allow this Doctor's office to release confidential information for billing and other purposes. I request to amend information; it must be made in writing. If I request to access records, it must be made in writing. If I need a summary of my records, there will be a charge that I am responsible for.

I authorize payment of medical benefits directly to the doctor and understand that I am responsible for any co-pays or co-insurance directly related to services rendered.

\_\_\_\_\_  
Printed Name

Patient/Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Consent for Use or Disclosure of Health Information

### **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 our health information.

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

- We 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.

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 you sign this consent form. We reserve the right to change our privacy practices as described in that notice. If we made 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 let 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 may 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 receive 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 its terms. I am also acknowledging that I have received a copy of this notice.

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Printed Name

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Signature

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Date

## Appointment Reminders and Health Care Information Authorization

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 alternative, or other health related information that may be of interest to you. If this contact is made by phone and you are not at home, a message will be left on your answering machine. By signing this form, you are giving us authorization to contact you with these reminders and information.

You may restrict the individuals or organizations to which your health care information is released or you may revoke your authorization to use at any time; however, your revocation must be in writing and mailed to us at our office address. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. In addition, 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.

Information that we use or disclose based on the authorizations you are giving us may be subject to redisclosure by anyone who has access to the reminder or other information and may no longer be protected by the federal privacy rules.

You have the right to refuse to give us this authorization. If you do not give us authorization, it will not affect the treatment we provide to you or the methods we use to obtain reimbursement for your care.

You may inspect or copy the information that we use to contact you to provide appointment reminders, information about treatment alternative, or other health related information at any time.

This notice is effective as of the date below. This authorization will expire seven years after the date on which you last received services from us.

I authorize you to use or disclose my health information in the manner described above. I am also acknowledging that I have received a copy of this authorization.

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Patient name printed

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Signature

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Date

## Health and Medical Information Release Form

I, \_\_\_\_\_, give permission to Dr. Ted Glazer, his staff, associates, and employees of Chiropractic Spine Center to share private and medical information with my medical doctor, \_\_\_\_\_, as well as his or her staff, employees and associates. Also, my medical doctor, as well as his/her staff, employees and associates have permission to share personal and medical information with Dr. Glazer and his staff.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### Patient Information

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### Medical Doctor Information

Doctor's Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_