

SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.
Dr. Timothy A. Swank, D.C., C.C.S.P.

**NOTE: If this is a Auto Accident or Workers' Compensation Case please tell Receptionist NOW
before starting this form.**

Date: _____ Name: _____
Permanent Address: _____
City: _____ State: _____ Zip: _____
Phones: Home: _____ Cell: _____ Work: _____
Birth Date: _____ Sex: M F SS# _____ E-mail: _____
Marital Status: S M W D # of Children: _____ Spouse Name: _____
Emergency Contact: _____ Phone _____
Business/ Employer: _____ Occupation: _____
How did you find out about our office? _____
(If referred by someone, please give us their name so we can thank them!)
Who is your Primary M.D.? _____ Phone _____

Primary Health Insurance

Secondary Insurance

Name of Ins: _____
Subscriber's Name: _____
Subscriber's DOB: _____
Subscriber's Employer: _____
Policy #: _____
Group #: _____
Ins. Effective Date: _____

Name of Ins: _____
Subscriber's Name: _____
Subscriber's DOB: _____
Subscriber's Employer: _____
Policy #: _____
Group #: _____
Relationship to Patient: _____

PLEASE READ CAREFULLY AND SIGN BELOW

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. If applicable, I understand that Swank Chiropractic Center, PA 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 to this Chiropractic Office will be credited to my account upon receipt. I also give this office power of attorney to endorse checks made out to me, to be credited to my account. However, I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment.

I hereby authorize and release the doctor and his/her assistants to administer treatment, physical examinations, X-ray studies, laboratory procedures, chiropractic care or any other services that he deems necessary in my case: and I further authorize him /her to disclose all or part of my patient record to any person or corporation which is or may be liable under a contract to the clinic ,or to the patient or to a family member or employer of the patient for all or part of the services rendered to me including and not limited to hospital or medical service companies, insurance co., worker's compensation carriers, welfare funds or employers.

Acknowledgement of Receipt: I acknowledge that I have received a copy of Swank Chiropractic Center, P.A. Financial and Consent Policies and I fully understand and agree to each item listed.

Patients Signature: _____ Date: _____

Authorization to Treat Minor

I hereby represent the above named patient as a MINOR and give authorization for full chiropractic care and treatments. I agree to be financially responsible for services rendered to minor listed above.

Parent/ Guardian Signature: _____ Relationship: _____
Date: _____ Witnessed by: _____

SWANK CHIROPRACTIC CENTER, P.A.

Name _____
Date _____ Case # _____

Medical Conditions

Circle whether you have had or currently have any of the following medical conditions:

- | | | |
|-------------------------|--------------------------|----------------------------|
| Heart Attack/Stroke | Arthritis | Severe/Frequent Headaches |
| Congenital Heart Defect | Frequent Neck Pain | Diabetes/Tuberculosis |
| Alcohol/Drug Abuse | Jaw Pain | Dizziness |
| Anemia | Wrist Pain | Emphysema/Glaucoma |
| Shingles | Shoulder Pain | Kidney Problems |
| Psychiatric Problems | Arm Pain | Artificial Bones/Joints |
| Difficulty Breathing | Leg Pain | Cancer |
| Hepatitis | Lower Back Problems | HIV Positive/AIDS |
| Food Allergies | Severe/Frequent Earaches | Ulcer/Colitis |
| Gout | Ringling in Ears | Fainting/Seizures/Epilepsy |

Family Health History

Many health problems are hereditary in nature and may be handed down generation after generation. Please review the below-listed diseases and conditions and indicate those that are current health problems of a family member. Leave blank those spaces that do not apply. If you require more space, use the reverse side of this form. Circle your answers if your relative lives around this locality, as some hereditary conditions are affected by similar climate.

Condition	Father Age ____	Mother Age ____	Spouse Age ____	Brothers Age ____	Sisters Age ____	Children Age ____
Arthritis	_____	_____	_____	_____	_____	_____
Asthma – Hay Fever	_____	_____	_____	_____	_____	_____
Back Trouble	_____	_____	_____	_____	_____	_____
Bursitis	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Constipation	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Disc Problems	_____	_____	_____	_____	_____	_____
Emphysema	_____	_____	_____	_____	_____	_____
Epilepsy	_____	_____	_____	_____	_____	_____
Headaches	_____	_____	_____	_____	_____	_____
Heart Trouble	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Insomnia	_____	_____	_____	_____	_____	_____
Kidney Trouble	_____	_____	_____	_____	_____	_____
Liver Trouble	_____	_____	_____	_____	_____	_____
Migraine	_____	_____	_____	_____	_____	_____
Nervousness	_____	_____	_____	_____	_____	_____
Neuralgia	_____	_____	_____	_____	_____	_____
Pinched Nerve	_____	_____	_____	_____	_____	_____
Scoliosis	_____	_____	_____	_____	_____	_____
Sinus Trouble	_____	_____	_____	_____	_____	_____
Stomach Trouble	_____	_____	_____	_____	_____	_____
Other: _____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____

If any of the above family members are deceased, please list their age at death and cause: _____

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NAME _____ DATE _____ CASE# _____

1. In general, would you say your health is:
 Excellent 1 Very good 2 Good 3 Fair 4 Poor 5

2. **Compared to 1 year ago**, how would you rate your health in general **now**?

Much better now than 1 year ago 1
 Somewhat better now than 1 year ago 2
 About the same 3
 Somewhat worse now than 1 year ago 4
 Much worse now than 1 year ago 5

The following items are about activities you might do during a typical day. **Does your health now limit you** in these activities? If so, how much?

CIRCLE ONE NUMBER ON EACH LINE

Cannot perform	Yes, but very limited and painful	Yes, but Somewhat Limited with mild pain	Yes, but Somewhat limited	Minimal limit	No Limits
----------------	-----------------------------------	--	---------------------------	---------------	-----------

- | | | | | | | |
|---|---|---|---|---|---|---|
| 3. Vigorous activities , such as running, lifting heavy objects, participating in strenuous sports | 1 | 2 | 3 | 4 | 5 | 6 |
| 4. Moderate activities , such as moving a table, pushing a vacuum cleaner, bowling or playing golf | 1 | 2 | 3 | 4 | 5 | 6 |
| 5. Lifting or carrying groceries | 1 | 2 | 3 | 4 | 5 | 6 |
| 6. Climbing several flights of stairs | 1 | 2 | 3 | 4 | 5 | 6 |
| 7. Climbing one flight of stairs | 1 | 2 | 3 | 4 | 5 | 6 |
| 8. Bending, kneeling or stooping | 1 | 2 | 3 | 4 | 5 | 6 |
| 9. Walking more than a mile | 1 | 2 | 3 | 4 | 5 | 6 |
| 10. Walking several blocks | 1 | 2 | 3 | 4 | 5 | 6 |
| 11. Walking one block | 1 | 2 | 3 | 4 | 5 | 6 |
| 12. Bathing or dressing yourself | 1 | 2 | 3 | 4 | 5 | 6 |

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of your physical health**?

CIRCLE ONE NUMBER ON EACH LINE

- | | Yes | No |
|---|-----|----|
| 13. Cut down the amount of time you spend on work or other activities | 1 | 2 |
| 14. Accomplished less than you would like | 1 | 2 |
| 15. Were limited in the kind of work or other activities | 1 | 2 |
| 16. Had difficulty performing the work or other activities
(for example it took extra effort) | 1 | 2 |

During the **past 4 weeks**, have you had any of the following problems with your work or other regular daily activities **as a result of any emotional problems** (such as feeling depressed or anxious)

CIRCLE ONE NUMBER ON EACH LINE

- | | Yes | No |
|--|--------------|---------------|
| 17. Cut down the amount of time you spend on work or other activities | 1 | 2 |
| 18. Accomplished less than you would like | 1 | 2 |
| 19. Didn't do work or other activities as carefully as usual | 1 | 2 |
| 20. During the past 4 weeks , to what extent has your physical health interfered with your normal social activities with family, friends, neighbors or groups? (circle 1 number) | | |
| | Not at all 1 | Slightly 2 |
| | Moderately 3 | Quite a bit 4 |
| | Extremely 5 | |

21. How much **bodily** pain have you had in the past 4 weeks? **(circle 1 number)**

- None 1 Very Mild 2 Mild 3 Moderate 4 Severe 5 Very Severe 6

22. During the **past 4 weeks**, how much did **pain** interfere with your normal work (Including work outside the house **and** house work) **(circle 1 number)**

- Not at all 1 Slightly 2 Moderately 3 Quite a bit 4 Extremely 5

These questions are about how you feel and how things have been with you **during the last 4 weeks**. For each question, please give the 1 answer that comes closest to the way you have been feeling. **How much of the time during the last 4 weeks...**

CIRCLE ONE NUMBER ON EACH LINE

	All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
--	-----------------	------------------	------------------------	------------------	----------------------	------------------

- | | | | | | | |
|-----------------------------------|---|---|---|---|---|---|
| 23. Did you have a lot of energy? | 1 | 2 | 3 | 4 | 5 | 6 |
| 24. Did you feel worn out? | 1 | 2 | 3 | 4 | 5 | 6 |
| 25. Did you feel tired? | 1 | 2 | 3 | 4 | 5 | 6 |

26. During the **past 4 weeks**, how much of the time has your **physical health** interfered with your social activities (like visiting with friends, relatives, etc.)?

- | | |
|----------------------|---|
| All of the time | 1 |
| Most of the time | 2 |
| Some of the time | 3 |
| A little of the time | 4 |
| None of the time | 5 |