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

Name of Ins: _________________________
Subscriber's Name: ______________________
Subscriber's DOB: ____________________
Subscriber's Employer: ______________________
Policy #: ____________________________
Group #: ____________________________
Ins. Effective Date: ____________________

Secondary Insurance

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

Name: ________________________________
Today's Date: __________Case # __________

Pre-consultation **Doctor's Notes**

Have you ever been under chiropractic care before? Yes No
Previous Chiropractic Care: ____
When? : _____________ *Where? :* ______________________________
MAJOR COMPLAINT: ____
Describe your pain and its location: ________________________________
When did the symptoms begin (date)? ________________________________
Other doctors seen for this condition: ________________________________
Is this related to an accident? _______________________________________
How did the accident occur? ____
Does the pain radiate into other areas? Yes No
If yes, please list other areas: ______________________________________
What makes your condition better? ___________________________________
What makes your condition worse? ___________________________________
Have you had similar conditions in the past? ___________________________
Activities or movements that you find difficult/painful to perform (circle):
Sitting Walking Bending Lying Lifting

Type of pain (circle all that apply): Sharp Dull Throbbing Aching Burning
Tingling Numbness Cramping Stiffness Swelling Other __________
Is pain interfering with: Work Sleep Daily Routine Recreation

Health History

Previous surgeries &/or hospitalizations with date/year: ___________________
____
____

Medications currently taking: *Prescribed*_______________________________
*Over the counter*___________________________
Vitamins currently taking: *Regularly* ___________________________________
Occasionally: ______________________________

Intake	How much, How often	Intake	How much, How often
Cigarettes	________________________	Coffee	________________________
Alcohol	________________________	Tea	________________________
Sugar	________________________	Drugs	________________________
Water	________________________	Exercise	________________________
Sleep	________________________	Appetite	________________________

FEMALES ONLY: Are you pregnant? Yes ___ No ___ Unsure ___ Date of last period _____________
Are you nursing? Yes ___ No ____

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	Ringing 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 1   Somewhat better 2   About the same 3   Somewhat worse 4   Much worse 5

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

   None 1   Very Mild 2   Moderate 3   Severe 4   Very Severe 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?

CHECK ONE BOX ON EACH LINE

Bending:	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Sit to Stand	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Climb Stairs	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Driving	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Computer Use	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Housework	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Kneeling	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Lifting/Carrying	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Dressing	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Reading (Concentration)	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Sleep	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Walking	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform
Exercise/Sports	☐**No Effect**	☐**Mild** Painful (can do)	☐**Moderate** Painful (Limited)	☐**Severe** Unable to Perform

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 <u>physical</u> 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 <u>emotional</u> 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. Had **difficulty** performing the work or other activities (for example it took extra effort)	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 Occasionally 3 Quite a bit 4 Always 5

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 Occasionally 3 Quite a bit 4 Always 5

23. During the past **4 weeks**, did you have a lot of energy? **(circle 1 number)**

Not at all 1 Slightly 2 Occasionally 3 Quite a bit 4 Always 5

24. During the past **4 weeks**, did you feel tired? **(circle 1 number)**

Not at all 1 Slightly 2 Occasionally 3 Quite a bit 4 Always 5