SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.

Timothy A. Swank, DC, CCSP, Parker A. Neill, DC, & Abigail L. Swank, DC

***NOTE:** If this is an **Auto Accident** or **Worker's Compensation Case** please tell receptionist **NOW** before starting this form**

Date: ___________________ Name: ____

Permanent Address: ____

City: ____________________________State: _________________________ Zip: ______________

Phone: Home: __________________ Cell: _________________ Work: _______________________

Birth Date: __________ Sex: M F SS# __________________E-mail: _______________________

Marital Status: S M W D # of Children: _______ Spouse Name: _________________________

Your 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 # ___________________

Emergency Contact Name: _____________________________ Phone #______________________

Please indicate how you would prefer to be reached for appointment reminders:

_____ Text message 1 to 2 days prior to my appointment: Cell phone provider

______ Email 1 to 2 days prior to my appointment

Primary Health Insurance

Name of Ins: ________________________

Subscriber's Name: ______________________

Subscriber's DOB: __________ __________

Subscriber's Employer: _______________________

Relationship to Patient: ________________

Policy #: ____________________________

Group#: ____________________________

Secondary Insurance

Name of Ins: __________________________

Subscriber's Name: _______________________

Subscriber's DOB: _______________________

Subscriber's Employer: _________________________

Relationship to Patient: __________________

Policy #: ______________________________

Group #: ______________________________

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:___________________

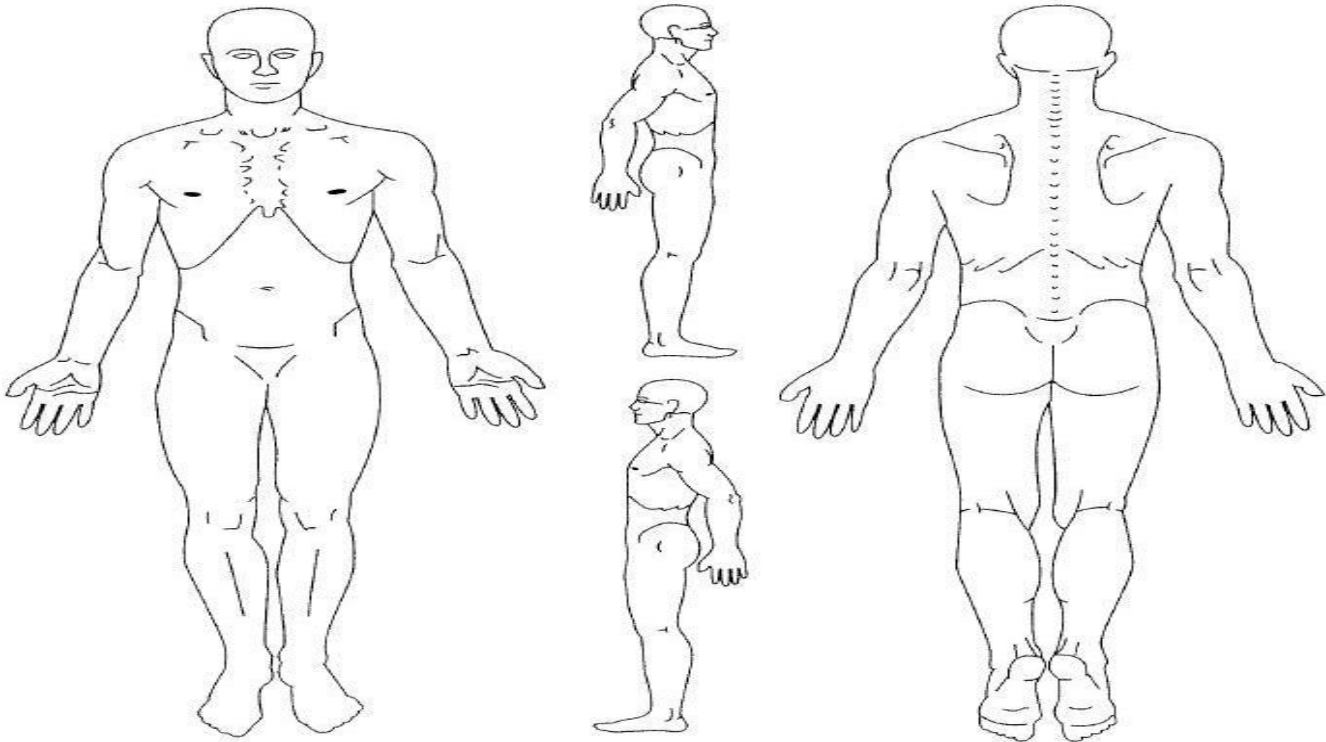
Date: _________________________________ Witnessed by: __________________________________

Patient Name: ________________________________ **Date:** __________**Case #:** ____________

Are you pregnant? Yes_____ No ______N/A______

Have you ever been under Chiropractic care? ____ If so, when? __________________________
Where? ____

By Using the key below, indicate on the body diagram where you are experiencing the following symptoms:
N=Numbness B=Burning S=Stabbing T=Tingling A=Dull Ache



Describe your symptoms in order of severity, with worse symptom being #1:
____
____

When did your symptoms begin? Month ____________ Day ________Year _______________

Are your symptoms a result of: Motor Vehicle Accident Work related Accident ☐Other ________

How did your symptoms begin? ____
____

How often do you experience your symptoms?

☐Constantly (76-100% of the day) ☐ Frequently (51-75% of the day) ☐ Occasionally (26-50% of the day) ☐ Intermittently (0-25% of the day)

What makes your condition better? ____
What makes your condition worse? ____

Doctor's Signature ____

Patient Name: ___________________________________ **Date**: _____________________ **Case #**:________

Medical Conditions: (Check all that apply to you)

☐ Arthritis	☐ Cancer	☐ Diabetes	☐ Heart Disease
☐ Hypertension	☐ Psychiatric Illness	☐ Skin Disorder	☐ Stroke

☐ Other ____

Surgeries: (Check all that apply to you)

☐ Appendectomy	☐ Cardiovascular procedure	☐Cervical spine	☐ Hysterectomy
☐ Joint Replacement	☐ Prostate	☐ Lumbar spine	☐ Gall Bladder
☐ Brain	☐ Shoulder	☐ Thoracic spine	☐ Knee
☐ Carpal Tunnel	☐ Gastro-intestinal	☐ Uro-genital	☐ Hernia

☐ Other ____

Allergies: (Check all that apply to you)

☐ Eggs	☐ Fish and Shellfish	☐ Milk or Lactose	☐ Peanuts
☐ Soy	☐ Sulfites	☐ Wheat/Glutens	☐ Other _________

Social History: (Check all that apply to you)

Caffeine use:	☐ occasional	☐ often	☐ never
Drink Alcohol:	☐ occasional	☐ often	☐ never
Exercise:	☐ occasional	☐ often	☐ never
Chew Tobacco:	☐ occasional	☐ often	☐ never
Cigarettes:	☐ <1 pack/day	☐ >1 pack/day	☐ never
Wear Seat Belts:	☐ occasional	☐ always	☐ never

Other ________________

Occupational Activities: (Check one that best describes your job description)

☐ Administration	☐ Business Owner	☐ Clerical/Secretary	☐ Computer User
☐ Heavy Equipment operator	☐ Daycare/Childcare	☐ Construction	☐ Health Care
☐ Food Service Industry	☐ Medium Manual Labor	☐ Manufacturing	☐ Home Services
☐ Heavy Manual Labor	☐ Light Manual Labor	☐ Executive/Legal	☐ Housekeeper

☐ Other ________________

Family 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	_______	_______	_______	_______	_______	_______
Diabetes	_______	_______	_______	_______	_______	_______
Disc Problems	_______	_______	_______	_______	_______	_______
Emphysema	_______	_______	_______	_______	_______	_______
Epilepsy	_______	_______	_______	_______	_______	_______
Headaches	_______	_______	_______	_______	_______	_______
High Blood Pressure	_______	_______	_______	_______	_______	_______
Insomnia	_______	_______	_______	_______	_______	_______
Kidney Trouble	_______	_______	_______	_______	_______	_______
Liver Trouble	_______	_______	_______	_______	_______	_______
Migraine	_______	_______	_______	_______	_______	_______
Pinched Nerve	_______	_______	_______	_______	_______	_______
Scoliosis	_______	_______	_______	_______	_______	_______
Sinus Trouble	_______	_______	_______	_______	_______	_______
Stomach Trouble:	_______	_______	_______	_______	_______	_______
Other :__________	_______	_______	_______	_______	_______	_______

Doctor's Signature ____

Patient Name: ______________________________________ **Date:** _____________ **Case #:** _____________

<u>Review of Systems</u> – (Check box if you have had trouble with any of the following, circle NO if none)

Cardiovascular			No	**Respiratory**			No	**Allergic/Immunologic**			No
	Past	Present			Past	Present			Past	Present	
Poor Circulation				Asthma				Hives			
Hypertension				Tuberculosis				Immune Disorder			
Aortic Aneurism				Short Breath				HIV/AIDS			
Heart Disease				Emphysema				Allergy Shots			
Heart Attack				Cold/Flu				Cortisone Use			
Chest Pain				Cough							
High Cholesterol				Wheezing							
Pace Maker								**Ear, Nose and Throat**			No
Jaw Pain				**Eyes**			No		Past	Present	
Irregular Heartbeat					Past	Present		Difficulty Swallowing			
Swelling of legs				Glaucoma				Dizziness			
				Double Vision				Hearing Loss			
Genitourinary			No	Blurred Vision				Sore Throat			
	Past	Present						Nosebleeds			
Kidney Disease				**Psychiatric**			No	Bleeding Gums			
Burning Urination					Past	Present		Sinus Infections			
Frequent Urination				Depression							
Blood in Urine				Anxiety				**Gastrointestinal**			No
Kidney Stones				Stress					Past	Present	
Lower Side Pain								Gall Bladder Problems			
				Endocrine			No	Bowel Problems			
Neurologic			No		Past	Present		Constipation			
	Past	Present		Thyroid				Liver Problems			
Stroke				Diabetes				Ulcers			
Seizures				Hair Loss				Diarrhea			
Head Injury				Menopausal				Nausea/Vomiting			
Brain Aneurysm				Menstrual				Bloody Stools			
Numbness								Poor Appetite			
Severe Headaches				**Hematologic**			No				
Pinched Nerves					Past	Present		**Musculoskeletal**			No
Parkinson's				Hepatitis					Past	Present	
Carpal Tunnel				Blood Clots				Gout			
Vertigo				Cancer				Arthritis			
				Bruising				Joint Stiffness			
Constitutional			No	Bleeding				Muscle Weakness			
	Past	Present		Fever, Chills				Osteoporosis			
Difficulty Sleeping				Sweating				Broken Bones			
Weight Loss/Gain								Joints Replaced			
Low Energy Level											

Please list all current medications being taken

____

____

____

Doctor's Signature ______________________________________

Patient Name ________________________________ **Date:** ____________ **Case #:** __________

Employment, ADL, and Recreation Information

Outcomes Assessment Tool Used _________________________________ **Score** ________________

Description of Work: ____

Condition's Effect on Job Performance*:* ☐ **No Effect** ☐ **Mild** (painful can do) ☐ **Mod** (painful limited ability) ☐ **Mod/Sev (**limited duty) ☐ **Sev** (no limited duty) ☐ **Sev** (can't do limited duty)

Daily Activities: Effects of Current Condition on Performance

Activity				
Bending:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Care –Infirm Family:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Carrying Groceries:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Change Pos–Sit-Stand:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Climb Stairs:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Driving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Extended Comp Use:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Feeding:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Household Chores:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Kneeling:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lift Children:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Lifting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Pet Care:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Reading(Concentration)	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Bathing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Dressing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Self Care–Shaving:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sexual Activities:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Sleep:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Sitting:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Static Standing:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Walking:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform
Yard Work:	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (Limited)	☐ **Sev** Unable to Perform

Recreational Activity: Effects of Current Condition on Performance

Activity				
__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform
__________________	☐ **No Effect**	☐ **Mild** Painful (Can do)	☐ **Mod** Painful (limited)	☐ **Sev** Unable to Perform

Doctor's Signature ______________________________________

SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.

Timothy A. Swank, DC, CCSP, Parker A. Neill, DC & Abigail L. Swank, DC

Name: ______________________________
Date: _______________ Chart #: ______

ASSIGNMENT

I hereby instruct and direct my insurance company to pay by check made out and mailed directly to this clinic, the professional or medical expense benefit allowable and payable under my current insurance policy as payment toward the total charges for my professional services rendered in this office.

A photocopy of this assignment shall be considered as effective and valid as the original

RELEASE OF INFORMATION

I authorize this office known as Swank Chiropractic Center, P.A. to release any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case. I hereby forever release Swank Chiropractic Center, P. A., its agents and employees of any consequence thereof.

RELEASE OF MEDICAL RECORDS

You are hereby authorized and instructed to release to Timothy A. Swank , DC, Parker A. Neill, DC, & Abigail L. Swank, DC, Swank Chiropractic Center, P.A. all information/records concerning treatment and/or involvement in the care of my health.
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FINANCIAL RESPONSIBILITY

I agree to be financially responsible for all charges to Swank Chiropractic Center, P.A. including my insurance deductible, copayment, and any services rejected by my insurance company or any other entity responsible for payment.

REFERRALS/AUTHORIZATIONS

I agree to pay for all services when a referral from my primary care physician was not received prior to being seen, or authorization from my insurance company was not obtained at the time of my visit. ACKNOWLEDGMENT OF RECEIPT acknowledge that I have received a copy of Swank Chiropractic Center, P.A. financial and consent policies(found on website) and I fully understand and agree to each item listed.

I have read, understood, and accepted the items listed above.

____________________________________ ___________________________
(patient/guardian signature) (date)

SWANK CHIROPRACTIC SPORTS MEDICINE & WELLNESS CENTER, P.A.
Timothy A. Swank, DC, CCSP, Parker A. Neill, DC & Abigail L. Swank, DC

INFORMED CONSENT FORM

PATIENT NAME: ____________________________________ DATE: __________________

To the patient: Please read this entire document prior to signing it. It is important that you understand the information contained in this document. If anything is unclear, ask questions before you sign.

The nature of the chiropractic adjustment

The primary treatment I use as a Doctor of Chiropractic is spinal manipulative therapy. I will use that procedure to treat you. I will use my hands or a mechanical instrument upon your body in such a way as to move your joints. That may cause an audible "pop" or "click," much as you have experienced when you "crack" your knuckles. You may feel a sense of movement.

Analysis / Examination / Treatment

As a part of the analysis, examination, and treatment, you are consenting to the following procedures:

Spinal manipulation	palpation	vital signs
range of motion testing	orthopedic testing	basic neurological testing
muscle strength testing	posture pump	ultrasound
hot/cold therapy	electrical stim / H-Wave	radiographic studies
mechanical traction	Aqua med	Other (please explain)

____
____

The material risks inherent in chiropractic adjustment.

As with any healthcare procedure, there are certain complications which may arise during chiropractic manipulation and therapy. These complications include but are not limited to: fractures, disc injuries, dislocations, muscle strain, cervical myelopathy, costovertebral strains and separations, and burns. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment. I will make every reasonable effort during the examination to screen for contraindications to care; **however, if you have a condition that would otherwise not come to my attention, it is your responsibility to inform me.**

The probability of those risks occurring.

Fractures are rare occurrences and generally result from some underlying weakness of the bone which I check for during the taking of your history and during examination and X-ray. Stroke has been the subject of tremendous disagreement. The incidences of stroke are exceedingly rare and are estimated to occur between one in one million and one in five million cervical adjustments. The other complications are also generally described as rare.

The availability and nature of other treatment options

Other treatment options for your condition may include:

- Self-administered, over-the-counter analgesics and rest
- Medical care and prescription drugs such as anti-inflammatory, muscle relaxants and pain-killers
- Hospitalization
- Surgery

If you chose to use one of the above noted “other treatment” options, you should be aware that there are risks and benefits of such options and you may wish to discuss these with your primary medical physician.

The risks and dangers attendant to remaining untreated

Remaining untreated may allow the formation of adhesions and reduce mobility which may set up a pain reaction further reducing mobility. Over time this process may complicate treatment making it more difficult and less effective the longer it is postponed.

DO NOT SIGN UNTIL YOU HAVE READ AND UNDERSTAND THE ABOVE.

PLEASE CHECK THE APPROPRIATE BLOCK AND SIGN BELOW

I have read [ ] or have had read to me [ ] the above explanation of the chiropractic adjustment and related treatment. I have discussed it with Dr. Timothy Swank, Dr. Parker Neill, or Dr. Abigail Swank and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest to undergo the treatment recommended. Having been informed of the risks, I hereby give my consent to that treatment.

Dated: ______________

____
Patient’s Name

____
Signature

____
Signature of Parent or Guardian (If a minor)

Dated: ______________

____
Doctor’s Name

____
Signature