NOWOTARSKI CHIROPRACTIC & PHYSICAL THERAPY CENTER

3443 Penn Ave.
Sinking Spring, PA
(610) 678-8600

Personal Information | *Please supply the following:*

Name: _____ Occupation: _____

Date: _____ Employer & Address: _____

Address: _____ _____

_____ Marital Status: _____

Home Phone: _____ Spouse's Name: _____

Cell Phone: _____ Spouse's Employer: _____

Work Phone: _____ Any previous chiropractic care? _____

Social Security #: _____ If yes, when? By whom? _____

Sex: M F _____

DOB: / / Age: _____ Referred by: _____

Case History | *Please answer these questions as completely as possible.*

What is your major problem? _____

When did it start? _____ Was it: SUDDEN / GRADUAL ONSET

What caused it? _____

Have you had this before? _____ If so, when? _____

Is it: GETTING BETTER / GETTING WORSE / STAYING THE SAME

Is the pain: SHARP / DULL / BURNING / TINGLING / ACHING / OTHER

Is the pain: MILD / MODERATE / SEVERE / CONTINUOUS / OFF AND ON

When is it worse: MORNING / AFTERNOON / EVENING / DURING SLEEP

What activities make it worse? _____

What makes it feel better? _____

Does it interfere with: SLEEP / WORK / PLAY / OTHER

Have you been treated for this before? _____ If so, by whom? When last?

Are you taking medication for any reason? _____ If yes, what?

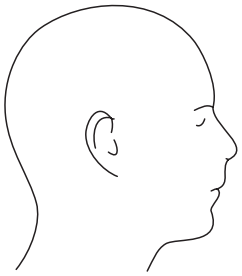
Case History, Cont'd | *Please check the appropriate boxes*

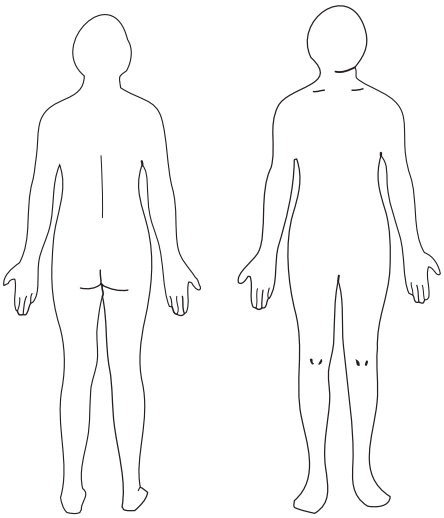
PAST	NOW		PAST	NOW		PAST	NOW	
☐	☐	High blood pressure	☐	☐	Constipation	☐	☐	Headaches
☐	☐	Heart trouble	☐	☐	Urination problems	☐	☐	Eye problems
☐	☐	Chest pain	☐	☐	Kidney problems	☐	☐	Ear problems
☐	☐	Stroke	☐	☐	Prostate problems	☐	☐	Sinus problems
☐	☐	Diabetes	☐	☐	Menstrual cramps	☐	☐	Throat problems
☐	☐	Cancer	☐	☐	Excessive flow	☐	☐	Dizziness
☐	☐	Digestive problems	☐	☐	Irregular cycles	☐	☐	Emotional problems
☐	☐	Diarrhea	☐	☐	Breast problems	☐	☐	Weight changes

Current Medical Complaints | *Please fill out completely*

Please indicate the appropriate location of pain and the symbol that best describes the discomfort you are presently experiencing:

Sharp and stabbing: + + + +
Dull and aching: V V V V
Pins and needles: o o o o o
Numbness: / / / / / / /





How would you rate your pain intensity?

☺ 0 1 2 3 4 5 6 7 8 9 10 ☹

Please describe other medical complaints: _____

Any other health problems that you are aware of: (accidents, surgeries, hospitalizations, etc.) _____

_____

Family history of disease: (heart problems, diabetes, etc.) _____

Office Policy | *Please read the policy and sign below*

This office will prepare and submit, at no cost to the patient, all necessary insurance claim forms. We also accept assignment, provided that: the insurance pays for chiropractic office visits & therapy, the patient pays in advance the outstanding deductibes and co-pays, and the patient pays for all non-covered services. If payment is made directly to the patient by the insurance company, the patient agrees to pay, within 5 days of receipt, that amount plus any outstanding balances. Should the patient terminate or suspend care from this office, or be released from treatment by this office, any outstanding balances will be paid withing 5 days of said termination.

I understand that if my insurance does not pay withing 30 days of claim submission, I will be responsible for the balance due at that time. I will personally contact my insurance company if there are problems with the payment. Ultimately, it is my responsibility to settle any outstanding balance in the office.

I have read the above office policy and I have agreed to comply fully with all of the provisions as evidenced by my signature below.

Patient Signature: _____ Date: _____