GIOLEKAS SPORTS & FAMILY CHIROPRACTIC

488 Pleasant Street | Worcester, MA 01609
Phone 508-752-7334 | Fax 508-752-8469

Name_____ Date of Birth_____

Address_____ City_____ State_____ Zip Code_____

Cell Phone_____ Home Phone_____ Sex at Birth M F

Occupation _____ Marital Status: M S W D CHILDREN #_____

How were you notified of this office? _____

HEALTH INFORMATION

What is your main complaint?_____

_____

How do you believe your pain began?_____

_____

When did you first notice this problem/pain? (Date, Time, ETC.)_____

Is this condition: ( ) Getting Worse ( ) Getting Better ( ) Staying the Same

Does this condition interfere with: ( ) Work ( ) Sleep ( ) Daily routine ( ) Other

Have you ever had this or similar conditions in the past? ( ) Yes ( ) No If yes, when?_____

How did the condition resolve?_____

What positions or activities aggravate your condition?_____

What positions or activities relieve your condition?_____

Have you ever seen any other doctors for this condition (Who)?_____

Have you had any prior: ( ) X-rays ( ) MRI ( ) CT Scans ( ) Other tests

Have you ever been in any accidents? (auto, slips or falls, etc.) If yes when?_____

_____

List all medication/vitamins that you are now taking and for what for:_____

_____

Have you ever been hospitalized or had any surgeries? ( ) Yes ( ) No

If yes, given reason and year: _____

_____

Please note any prior disease or conditions that have been diagnosed (Such as Diabetes, Heart disease, high blood pressure etc.) or additional conditions that I should be aware of prior to treating you:_____

Please note any family history of disease or illness (Heart Disease, Cancer, etc.)_____

What is the approximate date of your last physical examination?_____ By whom?_____

Have you ever had Chiropractic care? ( ) Yes ( ) No By whom?_____

Please Check Any Significant Symptoms That You Have Experienced or Currently Experience

GENERAL
( ) ALLERGY
( ) CHILLS
( ) CONVULSION
( ) DIZZINESS
( ) FAINTING
( ) FEVER
( ) HEADACHE
( ) LOSS OF SLEEP
( ) LOSS OF WEIGHT
( ) NERVOUSNESS
( ) DEPRESSION
( ) SWEATS
( ) TREMORS

GASTRO-INTESTINAL
( ) CONSTIPATION
( ) DIARRHEA
( ) DIGESTIVE PROBLEMS
( ) GALL BLADDER PROBLEMS
( ) HEMORRHOIDS
( ) LIVER PROBLEMS
( ) NAUSEA
( ) STOMACH PAIN
( ) POOR APPETITE
( ) VOMITING
( ) VOMITING BLOOD
( ) COLON TROUBLE

MUSLCE & JOINT
( ) LOW BACK PAIN
( ) MUSCLE SPASMS
( ) NECK PAIN
( ) MID/UPPER BACK PAIN
( ) SWOLLEN JOINTS
PAIN/NUMBNESS IN THE:
( ) SHOULDERS
( ) ARMS
( ) ELBOWS
( ) HANDS
( ) HIPS
( ) LEGS
( ) KNEES
( ) FEET

SKIN
( ) BOILS
( ) BRUISE EASILY
( ) COLD SORES
( ) DRYNESS
( ) RASHES/HIVES
( ) VARICOSE VEINS

RESPIRATORY
( ) CHRONIC COUGH
( ) DIFFICULTY BREATHING
( ) COUGHING UP BLOOD
( ) COUGHING UP PHLEGM
( ) WHEEZING

EAR-NOSE-THROAT
( ) FREQUENT COLDS
( ) EARACHE
( ) EAR NOISES
( ) EYE DISCHARGE
( ) POOR VISION
( ) NOSE BLEEDS
( ) SINUS TROUBLE
( ) DEAFNESS
( ) EAR DISCHARGE
( ) ENLARGED GLANDS
( ) EYE PAIN
( ) DENTAL PROBLEMS
( ) NASAL OBSTRUCTION
( ) LARYNGITIS

GENITO-URINARY
( ) BED WETTING
( ) BLOOD IN URINE
( ) FREQUENT URINATION
( ) KIDNEY INFECTION
( ) PAINFUL URINATION
( ) PUS IN URINE
( ) KIDNEY PROBLEMS

CARDIOVASCULAR
( ) CHEST PAIN
( ) ARTERIOSCLEROSIS
( ) HIGH BLOOD PRESSURE
( ) LOW BLOOD PRESSURE
( ) POOR CIRCULATION
( ) RAPID HEAR BEAT
( ) SLOW HEART BEAT

HABITS
( ) ALCOHOL – AMOUNT PER DAY/HOW MANY YEARS? _____
( ) TOBACCO – AMOUNT PER DAY/HOW MANY YEARS?_____
( ) DRUGS – AMOUNT PER DAY HOW MANY YEARS?_____
( ) EXERCISE – AMOUNT PER WEEK_____

ARTIFICIAL PROSTHESES
( ) DENTURES
( ) CONTACT LENSES
( ) HEARING AID
( ) SURGICAL IMPLANTS

WOMEN ONLY – Please Check if Apply

ARE YOU PREGNANT? ( ) **YES ( ) NO** ( ) CRAMPS ( ) EXCESSIVE FLOW ( ) HOT FLASHES

( ) IRREGULAR CYCLE ( ) LUMPS IN BREAST ( ) PAINFUL MENSTRUATION ( ) VAGINAL DISCHARGE

PAYMENT INFORMATION

HOW WILL SERVICES RENDERED TO YOU BE COVERED? (PLEASE CHECK BOX)

WORKERS' COMPENSATION ( ) HEALTH INSURANCE ( ) AUTO ( ) DEBIT/CREDIT CARD ( )
MEDICARE ( ) CASH ( ) CHECK ( ) FSA/HRA CARD ( )

IF YOU HAVE HEALTH INSURANCE PLEASE FILL OUT THE FOLLOWING INFORMATION OR PROVIDE A COPY OF YOUR INSURANCE CARD TO OUR OFFICE TO BE PHOTOCOPIED.

INSURANCE COMPANY_____

MEMBERSHIP# _____ PHONE#_____

I understand that there is no guarantee that my insurance companies or health plan will cover or pay for all of my charges. Not withstanding denial, reduction of benefits or failure to pay for any reason, I understand that I am responsible for all remaining charges that the practice can charge me based on my health plan benefits. I understand that the office has the right to charge me for missed appointments.

DATE_____ PATIENT SIGNATURE_____

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PRIVACY NOTICE ACKNOWLEDGEMENT

We are very concerned with protecting your privacy, especially in matters that concern your personal health information. In accordance with the *Health Insurance Portability and Accountability Act* of 1996 (HIPAA), we are required to supply you with a copy of our privacy policies and procedures. We encourage you to read this document carefully, for it outlines the use and limitations for the disclosure of your health information and your rights as a patient. Please note this document is also posted in the office and on our website. If you ever have any questions or concerns regarding the use of dissemination or your personal health information, we would be happy to address them.

I acknowledge I have received a copy of Giolekas Sports and Family Chiropractic, Inc.'s *Notice of Privacy Practices for Protected Health Information,* I also understand that this privacy notice is posted in the office and on giolekaschiropractic.com.

Printed Patient Name	Date
Patient Signature	Authorized Provider Rep
Personal Representative Printed	Personal Rep Signature

Description of personal representative's authority to act for the patient

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Insurance Benefit Determination

This office attempts to determine your insurance benefits based on the information we have at the time of service. However, insurance plans and insurance carriers are constantly changing and at times websites are not up to date. We will continue to provide you with the most up to date information that we have available.

However, it is your responsibility to have an understanding of your insurance coverage which may include mandatory referrals, copayments, co-insurance and/or deductibles.

Thank you for your understanding of this matter.

_____
Patient Name Printed

_____ _____
Patient Signature **Date**

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ASSIGNMENT OF INSURANCE BENEFITS

Patient Name_____

Date of Birth_____

I irrevocably authorize the _____ to make
(Insurance Company Name)
direct payment to Giolekas Sports and Family Chiropractic, Inc. at 488 Pleasant Street, Worcester, MA 01609 for any and all insurance benefits or reimbursement for services rendered by them which amounts would otherwise be payable to me under any insurance or pre-paid health care plan.

_____ _____
Date Patient's Signature

RELEASE OF INFORMATION

I authorize the release of any information concerning my health and health care service to my insurance companies, pre-paid health plan or Medicare by Giolekas Sports and Family Chiropractic, Inc.

_____ _____
Date Patient's Signature