

Zdilla Family Chiropractic

540 Broad Ave. Suite 1, Belle Vernon, PA 15012

phone 724.929.6777 fax 888.221.7407

Please print. All information will be kept confidential.

PATIENT INFORMATION							
Last Name			First		Middle		Today's Date
Address				City		State	Zip
Social Security No	Age	Birth Date	Sex	Marital Status	No. of Children	Home Phone	
Employer						Business Phone	
Occupation						Cell Phone	
Whom may we thank for referring you to our office?							
In case of Emergency notify				Relationship		Phone	
Family Doctor			Address			Phone	
Do you have medical insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Insurance Company			Policy No.		
Name of Spouse (if applicable)		Birth Date of Spouse (if applicable)		Employer of Spouse (if applicable)			
MAIN COMPLAINT(S) – PLEASE LIST ALL CURRENT COMPLAINTS							
The problem(s) I want the chiropractor to help me with is/are...							
When did you first experience these symptoms?			Is it getting worse? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does it... <input type="checkbox"/> bother you at work? <input type="checkbox"/> bother you at rest? <input type="checkbox"/> wake you from a sound sleep?		
What seemed to be the initial cause?				What makes it better?			
Are there sensations (pain, tingling, etc.) that seem to travel away from the main location and into neighboring areas? <input type="checkbox"/> Yes <input type="checkbox"/> No				What makes it worse?			
Have you seen a chiropractor before? <input type="checkbox"/> Yes <input type="checkbox"/> No		When?	Why?			Chiropractor's Name	
Are you being treated by any other healthcare provider? <input type="checkbox"/> Yes <input type="checkbox"/> No		If yes, for what?				Provider's Name	
Doctors Notes:							
Check all that apply and describe which <u>FAMILY MEMBER</u> is involved. <u>Immediate family only.</u>							
<input type="checkbox"/> Cancer				<input type="checkbox"/> Gastrointestinal Disease			
<input type="checkbox"/> Diabetes				<input type="checkbox"/> Genitourinary Disease			
<input type="checkbox"/> Lung Disease				<input type="checkbox"/> Joint Disease			
<input type="checkbox"/> Heart Disease				<input type="checkbox"/> Other			
<input type="checkbox"/> Musculoskeletal				<input type="checkbox"/> Other			
Doctors Notes:							

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Please check the box of all conditions you presently have or have had in the past.
We need your complete health history before we can be responsible for your care.

<u>Muscle/Joint</u>	<u>Eye, Ear, Nose and Throat</u>	<u>Women ONLY</u>	<u>Additional Conditions</u>
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Deafness	<input type="checkbox"/> Birth control	<input type="checkbox"/> AIDS/HIV
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Ear discharge	<input type="checkbox"/> Cramps	<input type="checkbox"/> Anorexia/Bulimia
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Ear noise	<input type="checkbox"/> Heavy menstruation	<input type="checkbox"/> Auto accident
<input type="checkbox"/> Mid back pain	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Hot flashes	<input type="checkbox"/> Fractures
<input type="checkbox"/> Low back pain	<input type="checkbox"/> Eye pain	<input type="checkbox"/> Irregular cycle	<input type="checkbox"/> Steroid use
<input type="checkbox"/> Jaw/TMJ pain	<input type="checkbox"/> Near/Far sighted	<input type="checkbox"/> Lumps in breast	<input type="checkbox"/> Tumors
<input type="checkbox"/> Herniated disc	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Menopause	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatoid Arthritis	<input type="checkbox"/> Nasal obstructions	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Anemia
<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Nose bleeds	<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Cancer
<input type="checkbox"/> Osteoporosis	<input type="checkbox"/> Sinus infections	<input type="checkbox"/> Vaginal infections	<input type="checkbox"/> Chicken pox
<input type="checkbox"/> Sciatica	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Currently pregnant # of months	<input type="checkbox"/> Depression
			<input type="checkbox"/> Diabetes
<u>General</u>	<u>Genitourinary</u>		<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Convulsions/Seizures	<input type="checkbox"/> Blood in urine	<u>Skin</u>	<input type="checkbox"/> Herpes
<input type="checkbox"/> Dizziness/Fainting	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Bruise easily	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Excessive fatigue	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Dryness	<input type="checkbox"/> Multiple sclerosis
<input type="checkbox"/> Excessive nausea	<input type="checkbox"/> Kidney infection	<input type="checkbox"/> Hives	<input type="checkbox"/> Mumps
<input type="checkbox"/> Excessive sweating	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Mole changes	<input type="checkbox"/> Parkinson's disease
<input type="checkbox"/> Headache/Migraine	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Mole surgeries	<input type="checkbox"/> Polio
<input type="checkbox"/> Head trauma	<input type="checkbox"/> Prostate condition	<input type="checkbox"/> Skin eruptions	<input type="checkbox"/> Rheumatic fever
<input type="checkbox"/> Memory loss		<input type="checkbox"/> Tattoos	<input type="checkbox"/> Scarlet fever
<input type="checkbox"/> Nervousness	<u>Respiratory</u>	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Stroke
<input type="checkbox"/> Depression	<input type="checkbox"/> Asthma		<input type="checkbox"/> Suicide attempt
<input type="checkbox"/> Sleep changes	<input type="checkbox"/> Bronchitis	<u>Gastrointestinal</u>	<input type="checkbox"/> Venereal diseases
<input type="checkbox"/> Weight changes	<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Appendicitis	
	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Bloody/black stools	
<u>Cardiovascular</u>	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Colitis	
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Spitting up blood	<input type="checkbox"/> Colon condition	
<input type="checkbox"/> High/Low BP	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Constipation	
<input type="checkbox"/> Heart pain	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Frequent diarrhea	
<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Indigestion	
<input type="checkbox"/> Rapid/Slow heart beat		<input type="checkbox"/> Pain w/swallowing	
<input type="checkbox"/> Pacemaker		<input type="checkbox"/> Hernia	
<input type="checkbox"/> High cholesterol		<input type="checkbox"/> Pancreatitis	
		<input type="checkbox"/> Reflux disease	

Notes: _____

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PLEASE LIST ANY INJURIES AND/OR SURGERIES YOU MAY HAVE HAD WITHIN THE PAST 10 YEARS

<input type="checkbox"/> Not applicable	Date
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

ALLERGIES

I am allergic to the following foods, drugs, cosmetics or other substances:

Not applicable, _____

EXERCISE

CHECK THE BOX THAT APPLIES TO YOU AND, IF INDICATED, FILL IN THE BLANK.

I do not exercise. I get my exercise at work. My duties at work consist of sitting,
 standing, walking, light labor, heavy labor. I exercise approximately ____ days per week.
When I exercise, the activity I do is usually _____ or _____. I consider
this to be light, moderate, or heavy.

HABITS

On average, I drink _____ alcoholic beverages per week. I smoke _____ packs of cigarettes per day
and have been smoking this amount for the past _____ years. On any given day, I drink _____
servings of caffeine (soda, coffee, tea, etc.) I have used needles within the past five years Yes No.

EXAMINATIONS

WHEN DID YOU LAST HAVE...

	Never	0-12 mo.	1-3 yrs	Longer
Spinal X-Ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spinal Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical Exam	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Notes: _____

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VITAMINS AND MEDICATIONS		
I am currently taking the following medication(s)	This medicine is supposed to help with my...	I first began this medicine in (give month and year if possible)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

I currently take the following vitamins, herbals and/or supplements	I take these vitamins, herbals or supplements because...	I've been using these vitamins or supplements since (give month and year if possible)
1.		
2.		
3.		
4.		
5.		
6.		
7.		

AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby agree to allow Dr. Michael Zdilla to release all medical information to my insurance carrier to allow for payment of insurance claims. This also authorizes my insurance carrier to pay Dr. Michael Zdilla directly for services provided. I understand that I am financially responsible *whether or not* my insurance company pays for all charges incurred by me. I will be notified as to any changes in agreement between my insurance carrier and Dr. Zdilla. I also understand that my account may not have an outstanding balance of greater than \$75. Accounts over 90 days delinquent will be subject to a \$10 MONTHLY BILLING FEE.

PATIENT'S SIGNATURE _____ DATE _____

PARENT'S SIGNATURE _____ DATE _____
(If patient is a minor)

Authorizations and Releases

Patient's name: _____ Date of Birth: _____ SS#: _____

Consent for Treatment:

I, the undersigned, hereby authorize Zdilla Family Chiropractic and their assistants to perform diagnostic tests, including but not limited to x-rays, and to administer treatment as is necessary.

I also certify that no guarantee or assurance has been made to the results that may be obtained. Any risks involving chiropractic treatment will be explained to me upon request.

Patient's signature: _____ Date: _____

Agreement for Payment of Services :

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that this office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that if any amount is authorized to be paid directly to this office, it will be credited to my account upon receipt. I permit this office to endorse remittances for the conveyance of credit 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 THE PAYMENT OF MY ACCOUNT.*** It is the policy of this clinic to collect for services as they are rendered, unless other financial arrangements are made.

Patient's signature: _____ Date: _____

Authorization to Release Medical Information:

I authorize the release of medical information necessary to process my insurance claim(s) and also certify that all insurance information given to this clinic is correct and complete.

Patient's signature: _____ Date: _____

Consent for Treatment of a Minor:

I hereby authorize Zdilla Family Chiropractic, and whomever they designate as their assistants, to perform diagnostic tests, including but not limited to x-rays, and to administer treatment as they deem necessary to my (indicate relationship of child) _____, (child's name) _____.

Guardian's signature: _____ Date: _____

A photocopy of this authorization will be treated in the same manner as the original