Clyde Park Chiropractic P.C.

Dr. Mary E. Gladish
4315 Clyde Park Ave SW
Wyoming, Michigan 49509

Date: _____ Name: _____
Social Security #: _____ Driver's License #: _____
Street Address _____ Apt. # _____ Date of Birth: _____
City _____ State _____ Zip _____ Email _____
Occupation _____ Employer _____
Home Ph ( ) _____ Work Ph ( ) _____ Cell ( ) _____
Spouses Name _____ Social Security # _____ Date of Birth _____
Spouses Employer _____ Work Ph ( ) _____
( ) Married ( ) Single ( ) Widow(er) ( ) Divorced ( ) Separated
EMERGENCY CONTACT AND PHONE NO: _____

PRESENT HEALTH PROBLEMS:
Please list below the five or more complaints you have in the order of importance. Also the length of time you have had these complaints.

1. _____ how long _____
2. _____ how long _____
3. _____ how long _____
4. _____ how long _____
5. _____ how long _____

Is condition related to an accident? Yes____ No____ Date of accident _____
Employment _____ Auto _____ Other _____
How and when did it start _____
What Doctors have you seen for this condition _____
Progress: Better_____ Worse_____ Other _____
What makes the condition worse_____
Have you ever been hospitalized? Yes_____ No____ When and when _____
Had surgery? Yes_____ No____ What operations and when _____
Had a major or minor fall or accident? Yes _____ No ____ What and when _____
Had a cracked or broken bone? Yes _____ No____ What and when _____
Are you pregnant at this time? _____

Personal habits:
Medication_____ Tobacco_____ Alcohol _____ Vitamins_____ Exercise _____
Other _____Medication and reason _____

Family History related to present condition: _____
Female history: Date of last menstrual cycle_____ regular _____ irregular _____
Birth control pills: Yes___ No ____ Are you pregnant at this time _____

Form of payment: Cash _____ Insurance and name of company _____
Insurance and name of company _____

I will be paying my co-pay today by: Cash _____ Check _____ Credit Card _____

I authorize payment of medical benefits to Clyde Park Chiropractic.
I authorize the Doctor to treat me.

Signed _____ Date _____

Referred by: _____

Description of Symptoms (Describe your symptoms in the sections below, in the order of severity, if possible.)

I. First Current Symptom: (Please check off the boxes below to describe your first symptom. Describe only ONE symptom per Section.)

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations :_____

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations :_____

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

1. Check only one body location below

	L	R	B
❑Headaches	❑	❑	❑
❑Front of Head			
❑Top of Head			
❑Back of Head			
❑Jaw	❑	❑	❑
❑Eye	❑	❑	❑
❑Neck	❑	❑	❑
❑Upper Back	❑	❑	❑
❑Mid Back	❑	❑	❑
❑Low Back	❑	❑	❑
❑Chest	❑	❑	❑
❑Abdomen	❑	❑	❑
❑Ribs	❑	❑	❑
❑Buttocks	❑	❑	❑
❑Shoulder	❑	❑	❑
❑Upper Arm	❑	❑	❑
❑Forearm	❑	❑	❑
❑Hand	❑	❑	❑
❑Hip	❑	❑	❑
❑Leg	❑	❑	❑
❑Foot	❑	❑	❑

Other locations :_____

2. Types of pain

❑ Dull ❑ Sharp ❑ Aching ❑ Cutting
❑Throbbing ❑ Burning ❑ Numbing ❑ Tingling ❑ Cramping
❑Spasm ❑ Stinging ❑ Shooting ❑ Pounding ❑Constricting

Other types of pain:
_____
_____

3. Pain Frequency

❑Up to 1/4 of awake time ❑1/4 to 1/2 of time
❑1/2 to 3/4 of awake time ❑ Most all the time

4. Pain Intensity (How it affects your daily activites)

❑ Doesn't affect ❑ Somewhat affects
❑ Seriously affects ❑ Prevents activities

5. Does this pain radiate into other body parts?

	Left	Right	Both
❑ Head	❑	❑	❑
❑ Neck	❑	❑	❑
❑ Shoulder	❑	❑	❑
❑ Arm	❑	❑	❑
❑ Hand	❑	❑	❑
❑ Hip	❑	❑	❑
❑ Leg	❑	❑	❑
❑ Foot	❑	❑	❑

Other locations of radiation:_____

6. Actions affecting this pain

	Brings On	Aggravates	Relieves
❑ In the A.M.	❑	❑	❑
❑ In the P.M.	❑	❑	❑
❑ Bending forward	❑	❑	❑
❑ Bending back	❑	❑	❑
❑ Bending left	❑	❑	❑
❑ Bending right	❑	❑	❑
❑ Twisting left	❑	❑	❑
❑ Twisting right	❑	❑	❑
❑ Coughing	❑	❑	❑
❑ Sneezing	❑	❑	❑
❑ Straining	❑	❑	❑
❑ Standing	❑	❑	❑
❑ Sitting	❑	❑	❑
❑ Lifting	❑	❑	❑
Other Actions:			
_____	❑	❑	❑
	❑	❑	❑

Activities of Daily Living Assessment

Rate your current difficulties, resulting from your accident/illness, with regard to the various activities listed below. Use the following 1 to 5 scale and **WRITE IN THE APPROPRIATE NUMBER** that most closely describes your current degree of difficulty: **1** = "I can do it without any difficulty", **2** = "I can do it without much difficulty, despite some pain", **3** = "I manage to do it by myself, despite marked pain", **4** = "I manage to do it, despite the pain, but only if I have help", **5** = "I cannot do it at all, because of the pain". **NOTE: Only fill in areas that are affected.**

Difficulties with Self Care and Personal Hygiene Activities

Bathing ..... ___	Drying hair ..... ___	Brushing teeth ..... ___	Putting on shoes ..... ___	Preparing meals ..... ___	Taking out trash .. ___
Showering ..... ___	Combing hair ..... ___	Making bed ..... ___	Tying shoes ..... ___	Eating ..... ___	Doing laundry ..... ___
Washing hair .. ___	Washing face ..... ___	Putting on shirt .... ___	Putting on pants ..... ___	Cleaning dishes ..... ___	Going to toilet ..... ___

Difficulties with Physical Activities

Standing ..... ___	Walking ..... ___	Kneeling ..... ___	Bending back ..... ___	Twisting left ..... ___	Leaning back..... ___
Sitting ..... ___	Stooping ..... ___	Reaching ..... ___	Bending left ..... ___	Twisting right ..... ___	Leaning left ..... ___
Reclining ..... ___	Squatting ..... ___	Bending forward .. ___	Bending right ..... ___	Leaning forward ..... ___	Leaning right ..... ___
Standing for long periods ..... ___		Sitting for long periods..... ___		Walking for long periods..... ___	Kneeling for long periods ..... ___

Difficulties with Functional Activities

Carrying small objects ..... ___	Lifting weights off floor ..... ___	Pushing things while seated .... ___	Exercising upper body ..... ___
Carrying large objects ..... ___	Lifting weights off table ..... ___	Pushing things while standing .. ___	Exercising lower body ..... ___
Carrying brief case ..... ___	Climbing stairs ..... ___	Pulling things while seated ..... ___	Exercising arms ..... ___
Carrying large purse ..... ___	Climbing inclines ..... ___	Pulling things while standing .... ___	Exercising legs ..... ___

Difficulties with Social and Recreational Activities

Bowling ..... ___	Jogging ..... ___	Swimming ..... ___	Ice Skating ..... ___	Competitive Sports . ___	Dating ..... ___
Golfing ..... ___	Dancing ..... ___	Skiing ..... ___	Roller Skating ..... ___	Hobbies ..... ___	Dining out ..... ___

Difficulties with Travelling

Driving a motor vehicle ..... ___	Riding as a passenger in a motor vehicle ..... ___	Riding as a passenger on a train ..... ___
Driving for long periods of time ..... ___	Riding as a passenger on an airplane ..... ___	Riding as a passenger for long periods ..... ___

Use the following **1 to 5** scale to describe the difficulties below:
1 = "This area is not affected by my condition", **2** = "This area is slightly affected by my condition", **3** = "My condition moderately restricts my ability in this area", **4** = " My condition seriously limits my ability in this area", **5** = "My condition prevents me from using this ability"

Difficulties with Different Forms of Communication

Concentrating....____ Hearing....____ Listening....____ Speaking....____ Reading....____ Writing....____ Using a keyboard....____

Difficulties with the Senses

Seeing.....____ Hearing.....____ Sense of touch.....____ Sense of taste.....____ Sense of smell.....____

Difficulties with Hand Functions

Grasping.....____ Holding.....____ Pinching.....____ Percussive movements.....____ Sensory discrimination.....____

Difficulties with Sleep and Sexual Function

Being able to have normal, restful nights sleep.....____ Being able to participate in desired sexual activity.....____

Write in below any additional information regarding your Activities of Daily Living (that wasn't covered above):

Prior Symptom History

Prior Similar Symptoms

- ❑ I have NOT had prior symptoms similar to my current complaints.
- ❑ My current complaints DID exist before, but have not been bothering me.
- ❑ My current complaints ALREADY existed and were worsened.

Has your History Contributed to your Current Symptoms?

- ❑ My history HAS contributed to my current symptoms.
- ❑ My history HAS NOT contributed to my current symptoms.
- ❑ I 'm NOT SURE if my history has contributed to my current symptoms.

My most recent prior similar symptoms (**if applicable**) occured.....____ ❑ months ago / ❑ years ago **Or on** Date: ____/____/____

Write in below any other Prior Symptom History, not covered above:

PATIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy, The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry Out treatment, payment, or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care the is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories this only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer.

You have the **right to review** our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name:_____ Signature:_____ Date:_____

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation, and money. We want you to know that all of our employees, managers and doctors continually undergo training so that they may understand and comply with government rules and regulations regarding the Health insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine appropriate uses of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any *way* to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know that we are not perfect! Because of this fact, our policy is to listen to our employees and our patients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly.

Thank you for being one of our highly valued patients.

CLYDE PARK CHIROPRACTIC, P.C.
Dr. Mary Gladish, D.C.
4315 Clyde Park Ave.
Wyoming, MI. 49509
(616) 532-4500
FAX (616) 532-7344

FINANCIAL AGREEMENT

TO WHOM IT MAY CONCERN:

By my signature below I am requesting that my doctor reduce normal and customary fees collected as to allow me to receive chiropractic care. My financial circumstances are such that if I were to fully pay the customary fees charged I would be forced (due to economic reasons) to not receive necessary care.

I recognize that any agreement made to assist me is purely confidential and that my fee arrangement will be different that which is standard in the office.

If my insurance company policy demands full payment of the deductible or co-pay, I agree that it is my responsibility to notify my insurance carrier that due to economic hardship I am only making partial payment.

Print Patient's Name: _____ Date: _____

Patient's Signature:_____

Witness' Signature: _____ Date: _____