# Czulada Chiropractic P.C.

**Glenn Czulada DC, 1201 Wheeler Ave, Dunmore, Pa. 18510 570) 343-0400**
**Todd Glidewell DC, 927 Main St, Dickson City, Pa. 18519 (570) 383-2222**

FILE #_____ DATE ___/___/___

## Patient Initial Health History

Name_____ SS#_____-_____-_____

Street _____City _____St_____Zip _____

Date of Birth:___/___/___Age:____ Sex: □M □F Marital Status: □M □S □W □D

Home Phone _____-_____ Cell Phone _____-_____

Email _____

Your Employer _____Your Occupation_____

Insurance Information (Please check type)

Medicare ____ Highmark_____ Group Coverage_____Work Comp ____Auto Injury ____

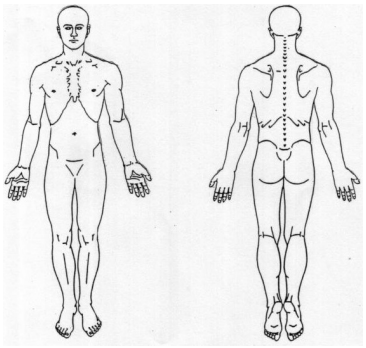
HMO _____None _____Pa Access(MA)____

Primary Insured: Self _____ Spouse ____ Other ____

If other than Self: Insured's Name _____ D.O.B. _____Employer _____

Please list the main reasons you are seeking our help:

1. _____How Long Have You Had This? _____
2. _____How Long Have You Had This? _____
3. _____How Long Have You Had This? _____



Mark with an X on the picture where you have pain or other symptoms.

How often are your symptoms present?

0 – 25% 26 – 50% 51 – 75% 76 – 100%

Mark your average pain over the last week

|----------|

0 1 2 3 4 5 6 7 8 9 10

Family Physician _____

How were you referred to our office?_____

Last Visit to a Chiropractor? _____Month ____Year ____Never

Do You Have a Pacemaker? □Yes □No Could You Be Pregnant? □Yes □ No

### Records Release

Czulada Chiropractic Offices is authorized to obtain, examine & make copies of medical records, x-rays and reports pertaining to your treatment of my condition. This authorization is valid until revoked in writing by me. A photocopy of this authorization and my signature has same effect as the original.

Patient Signature _____ Date ____/____/____

# Patient Initial Health History

Please mark all of the following that apply to you.

| NO | YES | Condition | NO | YES | Condition |
|---|---|---|---|---|---|
| | | History of recent infection | | | Recent Trauma |
| | | Recent fever | | | Prostate Problems |
| | | HIV/AIDS | | | Frequent urination |
| | | Diabetes | | | Pregnancy, # of births _____ |
| | | Corticosteroid use | | | Abnormal weight Gain Loss |
| | | Birth control pills | | | Epilepsy/ Seizures |
| | | High blood pressure | | | Visual Disturbances |
| | | Stroke (Date) _____ | | | History of Low/Mid back pain |
| | | Dizziness/ Fainting | | | History of neck pain |
| | | Numbness in Groin/ Buttocks | | | Arthritis |
| | | Urinary Retention | | | History of alcohol use |
| | | Aortic Aneurysm | | | History of tobacco use |
| | | Cancer/ Tumor | | | Surgeries/ Medications: |
| | | Osteoporosis | _____ | | |
| | | | _____ | | |

Family History:

Cancer Diabetes

High blood pressure Cardiovascular problems/ Stroke

Back Problems Scoliosis