File # _____

Czulada Chiropractic, PC

Dr. Glenn Czulada
Dr. Todd Glidewell

Reply to: 1201 Wheeler Ave, Dunmore, PA 18510 **570-343-0400** **FAX: 570-342-5877**
Reply to: 927 Main St, Dickson City, PA 18519 **570-383-2222** **FAX: 570-383-3851**

Patient Information

Date ____-____-18

Name_____

Street _____City _____St_____Zip _____

Date of Birth:____-____-_____Age:_____ Sex: □M □F Marital Status: □M □S □W □D

Home Phone _____ Cell Phone _____

Email _____

Your Occupation_____ 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? _____

How often are your symptoms present?

□ 0 – 25% □ 26 – 50% □ 51 – 75% □ 76 – 100%

Mark your average pain over the last week

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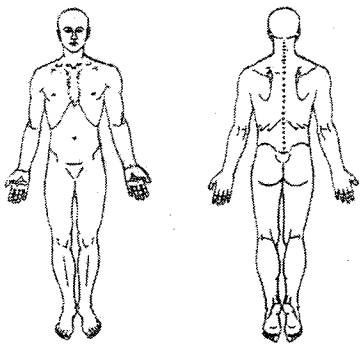
0 1 2 3 4 5 6 7 8 9 10



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

Last Visit to a Chiropractor? ____Months ____Years ____Never

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

Insurance Information (Please check type): None _____

Medicare ____ Blue Shield/Cross _____ Geisinger____ GHP Family _____

Other Group Coverage_____ Auto Injury _____ Work Comp _____

Primary Insured: Self _____ Spouse ____ Parent _____Other _____

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

Assignment of Insurance Benefits

I hereby assign all applicable health insurance benefits to which I am entitled to Czulada Chiropractic PC. I certify that the health insurance information that I provided is accurate as of the date set forth below and that I am responsible for keeping it updated.

I hereby authorize Czulada Chiropractic PC to submit claims, on my behalf, to the benefit plan (or its administrator) listed on the current insurance card I provided. I also hereby instruct my benefit plan (or its administrator) to pay Czulada Chiropractic PC directly for services rendered to me.

Patient Signature _____ Date _____-_____-_____

Patient Health History

Please check all of the following that apply to you: ☐ None Apply

YES	NO	Condition
☐	☐	History of Cancer/ Tumor
☐	☐	Recent fever
☐	☐	HIV/AIDS
☐	☐	Diabetes Type: I ☐ II ☐
☐	☐	High blood pressure
☐	☐	History of Stroke (Date) _____
☐	☐	Dizziness/ Fainting
☐	☐	Aortic Aneurysm
☐	☐	Prostrate Problems
☐	☐	Frequent Urination
☐	☐	Urinary Retention
☐	☐	Epilepsy/ Seizures
☐	☐	Visual Disturbances

YES	NO	Condition
☐	☐	Recent Trauma
☐	☐	Steroid Use
☐	☐	Birth Control Pills
☐	☐	Arthritis
☐	☐	Osteoporosis
☐	☐	History of Low/Mid back pain
☐	☐	History of neck pain
☐	☐	Numbness in Groin/ Buttocks
☐	☐	History of Alcohol Use
☐	☐	History of Tobacco Use
☐	☐	Pregnancy, # of Births _____
☐	☐	Abnormal weight ☐ Gain ☐ Loss
☐	☐	Anxiety/Depression

Health Conditions Not Listed:

_____

_____

_____

Surgical History

_____

_____

_____

_____

_____

_____

Family History:

☐ Cancer ☐ Diabetes

☐ Cardiovascular problems/ Stroke

☐ High blood pressure

☐ Back Problems ☐ Scoliosis

Current Medications

_____

_____

_____

_____