

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)

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. 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II. Second Current Symptom: (Please check off the boxes below to describe your next symptom).

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Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. 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III. Third Current Symptom: (Please check off the boxes below to describe your 3rd symptom).

<p>1. Check only one body location below</p> <p><input type="checkbox"/> Headaches L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Front of Head <input type="checkbox"/> Top of Head <input type="checkbox"/> Back of Head</p> <p><input type="checkbox"/> Jaw L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Eye L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Neck L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Mid Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Low Back L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Chest L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Abdomen L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Ribs L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Buttocks L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Shoulder L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Upper Arm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Forearm L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hand L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Hip L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Leg L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p><input type="checkbox"/> Foot L <input type="checkbox"/> R <input type="checkbox"/> B <input type="checkbox"/></p> <p>Other locations: _____</p>	<p>2. 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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) occurred..... ___ 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 than 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: _____