



Tucker Chiropractic & Wellness Center

402 Middletown Blvd, Suite 210, Langhorne, PA 19047 • Phone: (215) 750-8006 • Fax: (215) 750-8007

CONFIDENTIAL PATIENT INFORMATION

This information is confidential. If we do not sincerely believe your problem will respond favorably, we will not be able to accept your case. We will refer you to disciplines that we believe will help you. In order for us to understand your health problems, please complete this form neatly, accurately, and completely. Thank You.

Full Name _____ Birth date _____ Age _____ Sex M / F
 Address _____ City _____ State _____ Zipcode _____ SS# _____
 Phone: Home _____ Cell _____ E-mail _____
 Status (check one): Single , Married , Widowed , Divorced , Separated . Children: # _____, ages _____
 Occupation _____ Employer _____ Supervisor _____
 Work address _____ Work phone _____
 Spouse / Parent _____ Birth date _____
 In case of Emergency contact: _____ Relation _____ Phone _____
 Medical Doctor _____ Phone _____
 Doctor's address _____
 How did you hear about our office? _____
 Have you ever been to a Chiropractor? Y / N _____ Last visit date _____
 Describe results: _____

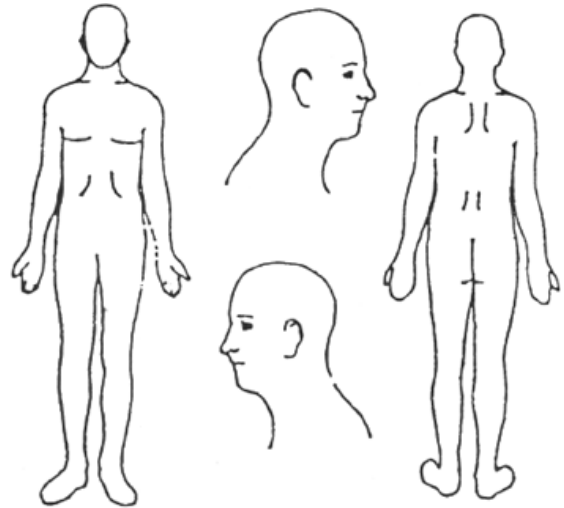
LIST COMPLAINTS: _____

Please mark your areas of pain on the figures below

PAIN LEVEL: RATE THE INTENSITY OF YOUR PAIN

mark an x next to the #

0	1	2	3	4	5	6	7	8	9	10
No		Low			Moderate			Intense		Excr.
Pain		Pain			Pain			Pain		Pain



WHICH OF THE FOLLOWING ACTIVITIES WORSEN YOUR CONDITION?

Nothing , Lifting , Getting up , Standing , Walking ,
Sitting , Movement , Inactivity , Work , Exercise .

IMPROVE YOUR CONDITION?

Nothing , Standing , Walking , Sitting , Movement , Sleep ,
Exercise , Inactivity , Lying down , Stretching ,
Hot Shower/Bath .

SYMPTOMS ARE WORSE: AM , MIDDAY , PM .

ARE THERE ANY ACTIVITIES THAT YOUR CONDITION INTERFERES WITH?

GIVE DETAILS: _____

IS YOUR CONDITION DUE TO AN ACCIDENT / FALL / ILLNESS / OTHER?

GIVE DETAILS: _____

List other Doctor(s) consulted for present complaints and injuries:

Name _____ Type of Doctor _____ When consulted _____

Treatments / x-rays _____ Diagnosis _____

How long did you see the Doctor? _____ How frequently? _____

Results: _____

Name _____ Type of Doctor _____ When consulted _____

Treatments / x-rays _____ Diagnosis _____

How long did you see the Doctor? _____ How frequently? _____

Results: _____

PAST MEDICAL HISTORY

List any medical conditions you have ever had / have and dates: _____

List any surgeries you have had and give dates: _____

Broken Bones: Which / When / Remarks: _____

List other accidents or serious falls: (auto, work home; leisure, sports, other) What / When / Treatment / Results: _____

For Women: Are you pregnant? Y / N First date of last menstrual cycle _____

List all medications you are now taking: _____

List all vitamins and supplements you are now taking: _____

Do you have a back brace? Y / N Is your pillow Comfortable? Y / N

How do you sleep? stomach , side , back .

How often do you use alcohol/tobacco? _____

INSURANCE INFORMATION

Insurance company _____ ID#: _____

Subscriber's name _____ Birth date _____

Address _____ City _____ State _____ Zip _____ SS# _____

ASSIGNMENT AND RELEASE

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and me. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I also understand that if I suspend or terminate, any fees for professional services rendered me will be immediately due and payable.

I here by authorize the Doctor to treat my condition as he or she deems appropriate. It is understood and agreed the amount paid the Doctor, for X-rays, is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all bills incurred at this office.

Patient's Signature _____ Date _____

Consent to Treat a Minor _____ Date _____

Guardian or Spouse's
Signature of Authorizing Care _____ Date _____



402 Middletown Blvd. Suite 210 • Langhorne, PA • Phone (215) 750-8006 • Fax (215) 750-8007

Consent Agreement

Consent to the Use and / or Disclosure of Health Information for Treatment, Payment or Healthcare Operations.

I _____, understand that as part of my treatment and care, this office creates and maintains health records describing my medical history, symptoms, examination and test results, diagnoses, treatment and any plans for future care and/or treatment. I understand that this information serves as:

1. A basis for planning my care and treatment.
2. A means of communication among the many healthcare professionals who contribute to my care.
3. A source of information for applying my diagnosis and surgical information to my bill.
4. A means by which a third-party payer can verify that services billed were actually provided.
5. A tool for routine healthcare operations such as assessing quality and reviewing the competence of our staff.
6. To call you and remind you of appointments.
7. To discuss your test results and treatment plan.

I understand if I wish to obtain a copy of the Office's Notice of Privacy Practices, that provides a more complete description of information uses and/or disclosures, one will be made available for me. I understand that I have a right to review the Notice prior to signing this consent. I understand that this Office reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised Notice to the address I've provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that this Office is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except that for actions taken by this Office in relying on such information.

I understand and authorize, that at times it will be necessary for this Office to call my home or place of business and leave messages on answering machines, voicemail or E-mail.

I fully understand and accept the terms of this consent.

Patient's Signature

Date

SYMPTOMS OF SPINAL MISALIGNMENT QUESTIONNAIRE

"The nervous system controls and coordinates all organs and structures of the human body." (Gray's Anatomy, 29th Ed., page 4). Misalignments of spinal vertebrae and discs may cause irritation to the nervous system and affect the structures, organs, and functions which may result in the conditions shown below. Please help us help you by placing a check mark in the appropriate box under the "Possible Effects" column to indicate your symptoms.

Vertebrae	Areas Controlled by Nerves*	Possible Effects of a Malfunction
1C	Blood supply to the head, pituitary gland, scalp, bones of the face, brain, inner and middle ear, sympathetic nervous system.	<input type="checkbox"/> headaches, <input type="checkbox"/> nervousness, <input type="checkbox"/> insomnia, <input type="checkbox"/> head colds, <input type="checkbox"/> high blood pressure, <input type="checkbox"/> migraine headaches, <input type="checkbox"/> nervous breakdowns, <input type="checkbox"/> amnesia, <input type="checkbox"/> chronic tiredness, <input type="checkbox"/> dizziness.
2C	Eyes, optic nerves, auditory nerves, sinus, mastoid bones, tongue, forehead.	<input type="checkbox"/> sinus trouble, <input type="checkbox"/> allergies, <input type="checkbox"/> crossed eyes, <input type="checkbox"/> deafness, <input type="checkbox"/> eye troubles, <input type="checkbox"/> earache, <input type="checkbox"/> fainting spells, <input type="checkbox"/> vision difficulties.
3C	Cheeks, outer ear, face bones, teeth, trifacial nerve.	<input type="checkbox"/> neuralgia, <input type="checkbox"/> neuritis, <input type="checkbox"/> acne or pimples, <input type="checkbox"/> eczema.
4C	Nose, lips, mouth, eustachian tube.	<input type="checkbox"/> hay fever, <input type="checkbox"/> hearing loss, <input type="checkbox"/> adenoids.
5C	Vocal cords, neck glands, pharynx.	<input type="checkbox"/> laryngitis, <input type="checkbox"/> hoarseness, <input type="checkbox"/> sore throats, <input type="checkbox"/> quincy.
6C	Neck muscles, shoulders, tonsils.	<input type="checkbox"/> stiff neck, <input type="checkbox"/> pain in upper arm, <input type="checkbox"/> tonsillitis, <input type="checkbox"/> whooping cough, <input type="checkbox"/> croup.
7C	Thyroid gland, bursae in the shoulders, elbows.	<input type="checkbox"/> bursitis, <input type="checkbox"/> colds, <input type="checkbox"/> thyroid conditions.
1T	Arms from the elbows down, including hands, wrists, and fingers; esophagus and trachea.	<input type="checkbox"/> asthma, <input type="checkbox"/> cough, <input type="checkbox"/> difficult breathing, <input type="checkbox"/> shortness of breath, <input type="checkbox"/> pain in lower arm, <input type="checkbox"/> pain in hands.
2T	Heart, including its valves and covering; coronary arteries.	<input type="checkbox"/> functional heart conditions, <input type="checkbox"/> chest conditions.
3T	Lungs, bronchial tubes, pleura, chest, breast.	<input type="checkbox"/> bronchitis, <input type="checkbox"/> pleurisy, <input type="checkbox"/> pneumonia, <input type="checkbox"/> congestion, <input type="checkbox"/> influenza.
4T	Gall bladder, common duct.	<input type="checkbox"/> gall bladder conditions, <input type="checkbox"/> jaundice, <input type="checkbox"/> shingles.
5T	Liver, solar plexus, blood.	<input type="checkbox"/> liver conditions, <input type="checkbox"/> fevers, <input type="checkbox"/> low blood pressure, <input type="checkbox"/> anemia, <input type="checkbox"/> poor circulation, <input type="checkbox"/> arthritis.
6T	Stomach.	<input type="checkbox"/> stomach troubles, <input type="checkbox"/> nervous stomach, <input type="checkbox"/> indigestion, <input type="checkbox"/> heartburn, <input type="checkbox"/> dyspepsia.
7T	Pancreas, duodenum.	<input type="checkbox"/> ulcers, <input type="checkbox"/> gastritis.
8T	Spleen.	<input type="checkbox"/> low resistance to colds and disease.
9T	Adrenal and supra-renal glands.	<input type="checkbox"/> allergies, <input type="checkbox"/> hives.
10T	Kidneys.	<input type="checkbox"/> kidney troubles, <input type="checkbox"/> hardening of the arteries, <input type="checkbox"/> chronic tiredness, <input type="checkbox"/> nephritis, <input type="checkbox"/> pyelitis.
11T	Kidneys, ureters.	<input type="checkbox"/> acne, <input type="checkbox"/> pimples, <input type="checkbox"/> eczema, <input type="checkbox"/> boils.
12T	Small intestines, lymph circulation.	<input type="checkbox"/> rheumatism, <input type="checkbox"/> gas pains, <input type="checkbox"/> sterility.
1L	Large intestines, inguinal rings.	<input type="checkbox"/> constipation, <input type="checkbox"/> colitis, <input type="checkbox"/> dysentery, <input type="checkbox"/> diarrhea, <input type="checkbox"/> ruptures, <input type="checkbox"/> hernias.
2L	Appendix, abdomen, upper leg.	<input type="checkbox"/> cramps, <input type="checkbox"/> difficult breathing, <input type="checkbox"/> acidosis, <input type="checkbox"/> varicose veins.
3L	Sex organs, uterus, bladder, knees.	<input type="checkbox"/> bladder troubles, <input type="checkbox"/> menstrual troubles such as painful or irregular periods, <input type="checkbox"/> miscarriages, <input type="checkbox"/> bed wetting, <input type="checkbox"/> impotency, <input type="checkbox"/> change of life symptoms, <input type="checkbox"/> knee pains.
4L	Prostate gland, muscles of the lower back, sciatic nerve.	<input type="checkbox"/> sciatica, <input type="checkbox"/> lumbago, <input type="checkbox"/> difficult, painful, or too frequent urination, <input type="checkbox"/> backaches.
5L	Lower legs, ankles, feet.	<input type="checkbox"/> poor circulation in the legs, <input type="checkbox"/> swollen ankles, <input type="checkbox"/> weak ankles and arches, <input type="checkbox"/> cold feet, <input type="checkbox"/> weakness in the legs, <input type="checkbox"/> leg cramps.
SACRUM	Hip bones, buttocks.	<input type="checkbox"/> low back pain, <input type="checkbox"/> spinal curvature.
COCCYX	Rectum, anus.	<input type="checkbox"/> hemorrhoids (piles), <input type="checkbox"/> pruritis (itching), <input type="checkbox"/> pain at end of spine on sitting.

* Directly or indirectly controlled

For further explanation of the conditions shown above, and information about those not shown, ask your Doctor of Chiropractic.