Skocik Chiropractic

Patient Name_____ **Date**_____

Address_____

City_____ **State**_____ **Zip**_____

Home Phone_____ **Cell Phone**_____

☐ **Opt in for appointment text messages**

Work Phone_____ **EXT**_____

Email Address_____ **Date of Birth**_____

Sex: M/F Marital Status: M / S / D / W

Occupation_____ **Employer**_____

Referred by:_____

Previous Chiropractic care? Y/N Chiropractor_____

Reason for being seen today (symptoms):

_____

Primary Reason (please describe): _____

_____

When did these symptoms begin? _____

Result of trauma? Yes/No If yes, please describe _____

_____

Secondary Reason (if any):

_____

When did these symptoms begin?_____

Emergency Contact _____ **Phone**_____

Relationship_____

PLEASE HAVE ALL INSURANCE CARDS AND PHOTO ID READY FOR FRONT DESK STAFF. THANK YOU.

AUTHORIZATION FOR ASSIGNMENT OF BENEFITS
FOR
SKOCIK CHIROPRACTIC
1111A S. GOVERNORS AVENUE, DOVER, DE 19904
PHONE 302-734-2225 FAX 302-734-2227

PLEASE READ AND SIGN THE FOLLOWING

1. I authorize this office to release or receive any information necessary to expedite insurance claims.
2. I hereby authorize this office to bill my insurance company directly for their services.
3. I authorize payment directly to this office/ Drs. Eric and Mimi Skocik of any insurance benefits otherwise payable to me.
4. In the event I receive payment from my insurance carrier, I agree to endorse any payment I receive over to this office/ Drs. Eric and Mimi Skocik for which these fees are payable.

I understand that I am directly and fully financially responsible to this office for any charges deemed as non-covered by my insurance company. I also understand that I am responsible for paying any co-pays, percentages and/or deductibles not covered by this insurance. I further understand that such payment is not contingent on any settlement, judgement or insurance payment by which I eventually recover said fee. I realize that if my insurance company fails to pay my balance in full, or there is no payment within 90 days, it is my full responsibility to pay my doctor's bill directly. I further understand and agree that if I fail to make timely payments on my account, I will be responsible for any and all reasonable costs of collection proceeding; including court costs, filling fees as well as reasonable attorney fees.

CONTRACTED INSURACE COVERAGE
If we are contracted with your insurance company, you will be expected to pay your co-pay/co-insurances/deductibles at the time of service.

ACCEPTED METHODS OF PAYMENT
We will accept payment of balances due by cash, check, money order, VISA, Mastercard, Discover, and American Express.

OTHER INFORMATION
There will be a service charge on all returned checks.

A photo copy of these authorizations and agreements shall be as valid as the original.

Printed name:_____

Signature:_____ Date:_____

INITIAL EVALUATION – Non Accident Related

LAST NAME: _____ FIRST NAME: _____ MI: ____ Date: _____

What brings you into our office? ☒ **Not accident related**

Do you feel your condition is: ☐ Improving ☐ Staying the same ☐ Getting worse

Have you lost time from work? ☐ Yes ☐ No

Can you perform physical work activities? ☐ Yes ☐ No

If no, because of: ☐ Pain ☐ Weakness ☐ Stress

Can you go to sleep without problems? ☐ Yes ☐ No

Do you awaken because of pain? ☐ Yes ☐ No

Did you have sleep problems before? ☐ Yes ☐ No

Activities of Daily Living Please select all activities which you are currently experiencing problems:

- ☐ Seeing
- ☐ Hearing
- ☐ Reading
- ☐ Holding
- ☐ Walking
- ☐ Kneeling
- ☐ Lifting
- ☐ Sitting
- ☐ Sports
- ☐ Reclining
- ☐ Insomnia
- ☐ Loss of concentration
- ☐ Change in personality
- ☐ Tasting
- ☐ Bathing
- ☐ Typing
- ☐ Pinching
- ☐ Stooping
- ☐ Bending
- ☐ Pushing
- ☐ Driving
- ☐ Exercising
- ☐ Restful Sleeping
- ☐ Using the toilet
- ☐ Smelling
- ☐ Grooming
- ☐ Writing
- ☐ Standing
- ☐ Squatting
- ☐ Twisting
- ☐ Pulling
- ☐ Riding in car
- ☐ Loss of sexual drive
- ☐ Nervous
- ☐ Tactile Feeling
- ☐ Eating
- ☐ Dressing
- ☐ Grasping
- ☐ Leaning
- ☐ Climbing
- ☐ Carrying
- ☐ Reaching
- ☐ Air Travel
- ☐ Irritable

Primary Reason

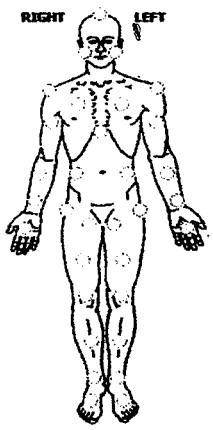
COMPLAINT # 1

(Initial Exam, Daily Note, Follow Up/Final Exam)

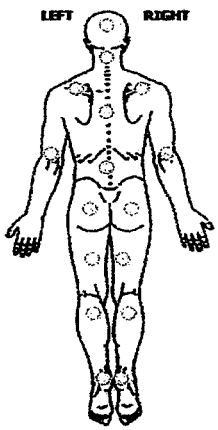
Complaint #1_____

Please place an X on one part of the body where you are experiencing pain or discomfort and list your complaints in the order of severity. (If you do not see your complaint on the picture, please list the complaint on the Other line.

Please grade pain 0-10 (10 is the highest) 0 1 2 3 4 5 6 7 8 9 10



Other:_____



Date Symptoms Began_____

Circle Location RIGHT LEFT BOTH

This complaint came on:	◻ Gradually	◻ Immediately	
It is getting:	◻ Improving	◻ Staying the same	◻ Getting Worse
The intensity of this complaint is:	◻ Minimal ◻ Slight	◻ Moderate	◻ Severe
The frequency of this complaint is: ◻Intermittent	◻ Occasional	◻ Frequent	◻ Constant
The pain is:	◻ Dull	◻ Sharp	◻ Aching
	◻ Shooting	◻ Spasm	◻ Throbbing
	◻ Burning	◻ Spasm	◻ Tingling
The pain is located on:	◻ Left side	◻ Right side	◻ Both sides

Actions effecting this complaint:

Morning	◻ Brings On	◻ Aggravates	◻ Relieves
Afternoon	◻ Brings On	◻ Aggravates	◻ Relieves
Bending Forward	◻ Brings On	◻ Aggravates	◻ Relieves
Bending Back	◻ Brings On	◻ Aggravates	◻ Relieves
Bending Left	◻ Brings On	◻ Aggravates	◻ Relieves
Bending Right	◻ Brings On	◻ Aggravates	◻ Relieves
Twisting Left	◻ Brings On	◻ Aggravates	◻ Relieves
Twisting Right	◻ Brings On	◻ Aggravates	◻ Relieves
Coughing	◻ Brings On	◻ Aggravates	◻ Relieves
Sneezing	◻ Brings On	◻ Aggravates	◻ Relieves
Straining	◻ Brings On	◻ Aggravates	◻ Relieves
Standing	◻ Brings On	◻ Aggravates	◻ Relieves
Lifting	◻ Brings On	◻ Aggravates	◻ Relieves
Sitting	◻ Brings On	◻ Aggravates	◻ Relieves
Heat	◻ Brings On	◻ Aggravates	◻ Relieves
Cold	◻ Brings On	◻ Aggravates	◻ Relieves
Rest	◻ Brings On	◻ Aggravates	◻ Relieves
Lying Down	◻ Brings On	◻ Aggravates	◻ Relieves

Secondary Reason (if any)

COMPLAINT # 2

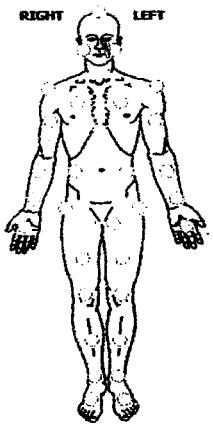
RAPID Doc Documentation

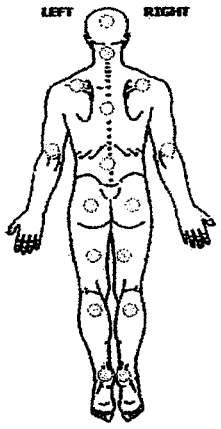
(Initial Exam, Daily Note, Follow Up/Final Exam)

Complaint # 2_____

Please place an X on one part of the body where you are experiencing pain or discomfort and list your complaints in the order of severity. (If you do not see your complaint on the picture, please list the complaint on the Other line.

Please grade pain 0-10 (10 is the highest) 0 1 2 3 4 5 6 7 8 9 10





Other:_____

Date Symptoms Began_____

Circle Location RIGHT LEFT BOTH

This complaint came on:	◻ Gradually	◻ Immediately	
It is getting:	◻ Improving	◻ Staying the same	◻ Getting Worse
The intensity of this complaint is:	◻ Minimal ◻ Slight	◻ Moderate	◻ Severe
The frequency of this complaint is: ◻Intermittent	◻ Occasional	◻ Frequent	◻ Constant
The pain is:	◻ Dull	◻ Sharp	◻ Aching
	◻ Shooting	◻ Spasm	◻ Throbbing
	◻ Burning	◻ Spasm	◻ Tingling
The pain is located on:	◻ Left side	◻ Right side	◻ Both sides
Actions effecting this complaint:			
Morning	◻ Brings On	◻ Aggravates	◻ Relieves
Afternoon	◻ Brings On	◻ Aggravates	◻ Relieves
Bending Forward	◻ Brings On	◻ Aggravates	◻ Relieves
Bending Back	◻ Brings On	◻ Aggravates	◻ Relieves
Bending Left	◻ Brings On	◻ Aggravates	◻ Relieves
Bending Right	◻ Brings On	◻ Aggravates	◻ Relieves
Twisting Left	◻ Brings On	◻ Aggravates	◻ Relieves
Twisting Right	◻ Brings On	◻ Aggravates	◻ Relieves
Coughing	◻ Brings On	◻ Aggravates	◻ Relieves
Sneezing	◻ Brings On	◻ Aggravates	◻ Relieves
Straining	◻ Brings On	◻ Aggravates	◻ Relieves
Standing	◻ Brings On	◻ Aggravates	◻ Relieves
Lifting	◻ Brings On	◻ Aggravates	◻ Relieves
Sitting	◻ Brings On	◻ Aggravates	◻ Relieves
Heat	◻ Brings On	◻ Aggravates	◻ Relieves
Cold	◻ Brings On	◻ Aggravates	◻ Relieves
Rest	◻ Brings On	◻ Aggravates	◻ Relieves
Lying Down	◻ Brings On	◻ Aggravates	◻ Relieves

INITIAL EVALUATION – Non Accident Related

RAPID Doc Documentation

Past Medical History

Please select all conditions that you have had or are currently having:

□ None	□ Other	□ Abdominal pain	□ Weight gain/loss	□ Angina
□ Anorexia	□ Anxiety	□ Aortic aneurysm	□ Arthritis	□ Asthma
□ Bladder infection	□ Blood disorder	□ Breast lumps	□ Breast soreness	□ Bronchitis
□ Cancer	□ Cardiovascular Dx	□Chest pain	□Chronic cough	□ Chronic sinusitis
□ Colitis	□ Constipation	□ Convulsions	□COPD	□ Depression
□ Dermatitis, Eczema/Rash	□ Diabetes	□ Difficulty in swallowing	□ Dizziness	□ Emphysema
□ Endometriosis	□ Epilepsy	□Excessive thirst	□Fainting	□ Frequent urination
□ General fatigue	□ Gout	□ Hand pain	□ Headache	□ Heart attack
□ Heart disease	□ Heartburn/Indigestion	□ Hepatitis	□ High Blood Pressure	□ High cholesterol
□ High PSA	□ High triglycerides	□ Hypertension	□ Irregular menstrual flow	□ Irritable colon
□ Jaw pain	□ Kidney disorders	□ Kidney stones	□ Liver / Gallbladder Problems	□ Loss of appetite
□ Loss of bladder control	□ Low back pain	□ Lung disease	□ Mental Disease	□ Mid back pain
□ Muscular in coordination	□ Neck pain	□ Osteoarthritis	□ Pain in ankle or foot	□ Pain in lower leg or knee
□ Pain in upper arm or elbow	□ Pain in upper leg and hip	□ Painful urination	□ PMS	□ Pneumonia
□ Profuse menstrual flow	□ Prostate problems	□ Rapid heartbeat	□ Renal disease	□Rheumatiod arthritis
□Scoliosis	□Shoulder pain	□Stroke	□ Swelling/stiffness joints	□Thyroid disease of
□Tinnitus/ ear noises	□ Tuberculosis	□ Tumor	□ Ulcer	□ Visual disturbances
□Wrist pain				

INITIAL EVALUATION – Non Accident Related

RAPID Doc Documentation

Family History

Please select all conditions that run in your family:

□ None	□ Other	□ Abdominal pain	□ Weight Gain/loss	□ Angina
□ Anorexia	□ Anxiety	□ Aortic aneurysm	□ Arthritis	□ Asthma
□ Bladder infection	□ Blood disorder	□ Breast lumps	□ Breast soreness	□ Bronchitis
□ Cancer	□ Cardiovascular Dx	□ Chest pain	□ Chronic cough	□ Chronic Sinusitis
□ Colitis	□ Constipation	□ Convulsions	□ COPD	□ Depression
□ Dermatitis, Eczema/Rash	□ Diabetes	□ Difficulty swallowing	□ Dizziness	□ Emphysema
□ Endometriosis	□ Epilepsy	□ Excessive thirst	□ Fainting	□ Frequent urination
□ General fatigue	□ Gout	□ Hand pain	□ Headache	□ Heart attack
□ Heart disease	□ Heartburn/Indigestion	□ Hepatitis	□ HBP	□ High cholesterol
□ High PSA	□ High triglycerides	□ Hypertension	□ Irregular menstrual flow	□ Irritable colon
□ Jaw pain	□ Kidney disorders	□ Kidney stones	□Liver/Gallbladder problems	□ Loss of appetite
□ Loss of bladder control	□ Low back pain	□ Lung disease	□ Mental disease	□ Mid back pain
□ Muscular coordination	□ Neck pain	□ Osteoarthritis	□ Pain in ankle or foot	□ Pain in lower leg or knee
□ Pain in upper arm or elbow	□ Pain in upper leg and hip	□ Painful urination	□ PMS	□ Pneumonia
□ Profuse menstrual flow	□ Prostate problems	□ Rapid heartbeat	□ Renal Dx	□ Rheumatoid arthritis
□Scoliosis	□Shoulder pain	□Stroke	□ Swelling/stiffness of joints	□ Thyroid disease
□ Tinnitus/ ear noises	□ Tuberculosis	□ Tumor	□ Ulcer	□ Visual disturbances
□ Wrist pain				

INITIAL EVALUATION – Non Accident Related

Surgical History

Please select all surgeries that you have had in the past.

☐ None	☐ Other	☐ Abdominal Exploration	☐ Abdominoplasty	☐ Abortion
☐ ACL Reconstruction	☐ Adenoid Removal	☐ Angioplasty	☐ Appendectomy	☐ Bone Fracture Repair
☐ Breast Lump Removal	☐ Bunion Removal	☐ Carotid Artery Surgery	☐ Cataract Surgery	☐ Cervical Spine Surgery
☐ Cholecystectomy	☐ Cosmetic Breast Surgery	☐ C-Section	☐ Facelift	☐ Gallbladder Removal
☐ Gastric Bypass	☐ Heart Bypass Surgery	☐ Heart Surgery	☐ Hemorrhoid Surgery	☐ Hernia Repair
☐ Hip Joint Replacement	☐ Hysterectomy	☐ Kidney Transplant	☐ Knee Arthroscopy	☐ Knee Joint Replacement
☐ Knee Surgery	☐ LASIK Eye Surgery	☐ Liposuction	☐ Lumbar Spine Surgery	☐ Mastectomy
☐ Prostate Removal	☐ Rotator Cuff Surgery	☐ TMJ Surgery	☐ Tonsillectomy	☐ Vasectomy

☐ Surgical History was reviewed:
Not contributory

Medications

Please select all medications that you are currently taking:

☐ None	☐ Other	☐ Analgesics	☐ Antacids	☐ Antibiotics
☐ Antihistamines	☐ Anti-Inflammatory	☐ Arthritis	☐ Aspirin	☐ Birth Control
☐ Blood Pressure	☐ Bone Density	☐ Cancer	☐ Cholesterol	☐ Daily Vitamins
☐ Diabetes	☐ Digestion	☐ Heart	☐ Muscle Relaxers	
☐ OTC	☐ Pain	☐ Steroids	☐ Thyroid	

Allergies

Please select all items that you are allergic to:

☐ None	☐ Other	☐ Chemical	☐ Environmental
☐ Food	☐ Medication	☐ Seasonal	

Social History

Please answer the following questions:

☐ Married	☐ Single	☐ Widowed	☐ Divorced	☐ Separated
Do you have any children?	☐ Yes ☐ No	If yes, how many? _____		
Do you use:	☐ Tobacco	☐ Alcohol	☐ Coffee	

Patient Name: _____ **Date:** _____

HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy describes how we may use and disclose your protected health information (PHI) to carry our treatment, payment or health care operations (TPO) for other purposes that are permitted or required by law. "Protected Health Information" is information about you, including demographic information that may identify you and that related to your past, present, or future physical or mental health or condition and related care services.

Use and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, pay your health care bills, to support the operations of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your health care information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, marketing, and fund raising activities, and conduction or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations included as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, and organ donation. Required uses and disclosures under the law, we must make disclosures to you when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES WILL BE MADE ONLY WITH YOUR CONSENT, AUTHORIZATION OR OPPORTUNITY TO OBJECT UNLESS REQUIRED BY LAW.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

_____ _____
Signature of Patient of Representative Date

_____
Printed Name

1111A South Governors Ave, Dover DE 19904 Phone (302) 734-2225 / Fax (302) 734-2227

INFORMED CONSENT FORM

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other licensed doctors of chiropractic who now or in the future work at the clinic or office listed below or any other office or clinic.

I have had an opportunity to discuss with the doctor(s) of chiropractic Eric V. Skocik/ Mimi R. Skocik and/or with other office or clinic personnel the nature and purpose of chiropractic adjustments and other procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine, in the practice of chiropractic there are some risks to treatment, including but not limited to fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

SKOCIK
CHIROPRACTIC
Accidents • Pain Management

Name of Patient_____ Date_____

WHAT TO EXPECT AFTER YOUR FIRST ADJUSTMENT

Please read the following information carefully. Sign the bottom of the sheet to indicate that you understand the instructions and information given.

1. If you have never received chiropractic treatment or if has been awhile since your last adjustment, you may experience soreness and/or discomfort for a few hours to a few days. This is a normal reaction to chiropractic adjustments.

2. If you are sore, use ice packs on the affected area(s). Ice therapy consists of the use of ice packs at 20 minute intervals followed by 40 minutes of rest. This can be repeated as often as needed. Do not apply ice directly to bare skin. Always protect skin with a thin covering such as a shirt or light towel. Cover the ice pack with a thin towel to retain the cold.

3. Do not use heat except under the doctor's instruction. Heat may aggravate your injury.

4. Stay away from heavy lifting or repetitive movements until the doctor indicates you are ready for normal activities. Strenuous athletic activities such as running, lifting weights, impact aerobics, racquet ball, tennis, skiing, bowling, etc. should be avoided. Other things to avoid are yard work such as groceries, pets and children, and any other activities that could aggravate or re-injure your condition.

5. Unless indicated by the doctor, you may return to work/school after your appointment.

6. If a sudden movement causes sharp or severe pain, or if you are experiencing swelling, contact the clinic at 302-734-2225.

I have read and understand the instructions given for my follow-up care.

_____ _____

Patient Signature Date

SKOCIK
CHIROPRACTIC
Accidents • Pain Management

Cancellation/No-Show Policy

Your appointment time is reserved especially for you. Please call our office to cancel your appointment at least 24 hours prior to your scheduled appointment if you will be unable to keep your appointment. This allows Drs. Eric Skocik/Mimi Skocik to offer that time to another patient. If a patient forgets or fails to show up for their appointment, there will be a $ 25.00 fee charged to your account. The same applies to appointments cancelled with less that 24 hours notice.

Thank you for your cooperation.

_____

Patient Signature

_____

Date