

Skocik Chiropractic

Motor Vehicle Collision Questionnaire

Patient Name _____ Date _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address: _____

Sex M F Marital Status M S D W Date of Birth _____ Age _____

Social Security# _____

Occupation _____

Employer _____

Referred by _____

Have you ever received Chiropractic Care? Yes No If yes, when? _____

Name of most recent Chiropractor _____

Reasons for seeking Chiropractor Care:

Primary Reason:
(Complaint # 1)

Secondary Reason:
(Complaint # 2 if any)

Emergency Contact:

Contact Name _____

Contact Phone # _____

Relationship _____

INITIAL EVALUATION – Automobile Accident



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

What brings you into our office? **Automobile Accident**

When did this accident happen? DATE: _____ WHERE: _____
TIME: _____ am/pm

What was your position in the vehicle?
 Driver Front Passenger Left Rear Passenger
 Middle Front Passenger Middle Rear Passenger Right Rear Passenger

What was the damage to the vehicle? Mild Moderate Extensive Totaled

How was the visibility on the road? Poor Fair Good

And the weather was:
 Clear Raining Windy Foggy Snowing

How did the accident happen?
 I hit another vehicle Another vehicle hit me I hit an object

What was the point of impact on our vehicle?
 Left Front end Rear end Right
 Left front Left rear Right front Right rear

Did you see the accident coming? Yes No

Were you braced for the impact? Yes No

Were you wearing a seatbelt? Yes No
If yes, does the seatbelt have a shoulder strap? Yes No

Does your vehicle have an airbag? Yes No

Did it deploy during the accident? Yes No

Does your vehicle have headrests? Yes No
What is the position of the headrest: Even with top of my head
 Even with bottom of my head
 Middle of neck

Did you strike anything inside the vehicle? Yes No

Your Vehicle Speed: _____
Other Vehicle Speed: _____

INITIAL EVALUATION – Automobile Accident



What inside your vehicle did you strike?

- Airbag Armrest Center Console Dashboard Gear shift lever/knob
 Headrest Rearview mirror Roof Rear window Seatback
 Side door Side window Wheel Windshield
 Other: _____

Immediately after the accident, did you feel dazed? Yes No

Did you lose consciousness? Yes No

Which way was your head turned during the accident?

- Facing straight forward Turned to the right Turned to the left

Was your head injured? Yes No

Immediately after the accident, did you experience: Headache Neck Pain Low Back Pain

Did you see another doctor before coming here? Yes No

Did you go to a hospital after the accident? Yes No If yes, which hospital? _____

How did you get to the hospital? Ambulance Drove self Somebody else Police

Were any of the following tests performed at the hospital?

- X-Rays MRI CT Scan Lab Work

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 Tasting Smelling Eating Hearing Insomnia
 Dressing Reading Typing Writing Grasping Using the toilet
 Standing Leaning Walking Stooping Squatting Loss of sexual drive
 Bending Twisting Carrying Lifting Pushing Restful sleeping
 Sitting Driving Sports Exercising Reclining Loss of concentration
 Irritable Riding in car Air travel Climbing Pulling Changes in personality
 Grooming Pinching Kneeling Reaching Nervous Tactile feeling

INITIAL EVALUATION – Non Accident Related



Past Medical History

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

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

INITIAL EVALUATION – Non Accident Related



Family History

Please select all conditions that run in your family:

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

INITIAL EVALUATION – Non Accident Related



Surgical History

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

- | | | | | |
|--|--|---|---|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Abdominal Exploration | <input type="checkbox"/> Abdominoplasty | <input type="checkbox"/> Abortion |
| <input type="checkbox"/> ACL Reconstruction | <input type="checkbox"/> Adenoid Removal | <input type="checkbox"/> Angioplasty | <input type="checkbox"/> Appendectomy | <input type="checkbox"/> Bone Fracture Repair |
| <input type="checkbox"/> Breast Lump Removal | <input type="checkbox"/> Bunion Removal | <input type="checkbox"/> Carotid Artery Surgery | <input type="checkbox"/> Cataract Surgery | <input type="checkbox"/> Cervical Spine Surgery |
| <input type="checkbox"/> Cholecystectomy | <input type="checkbox"/> Cosmetic Breast Surgery | <input type="checkbox"/> C-Section | <input type="checkbox"/> Facelift | <input type="checkbox"/> Gallbladder Removal |
| <input type="checkbox"/> Gastric Bypass | <input type="checkbox"/> Heart Bypass Surgery | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Hemorrhoid Surgery | <input type="checkbox"/> Hernia Repair |
| <input type="checkbox"/> Hip Joint Replacement | <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Kidney Transplant | <input type="checkbox"/> Knee Arthroscopy | <input type="checkbox"/> Knee Joint Replacement |
| <input type="checkbox"/> Knee Surgery | <input type="checkbox"/> LASIK Eye Surgery | <input type="checkbox"/> Liposuction | <input type="checkbox"/> Lumbar Spine Surgery | <input type="checkbox"/> Mastectomy |
| <input type="checkbox"/> Prostate Removal | <input type="checkbox"/> Rotator Cuff Surgery | <input type="checkbox"/> TMJ Surgery | <input type="checkbox"/> Tonsillectomy | <input type="checkbox"/> Vasectomy |
- Surgical History was reviewed:
Not contributory

Medications

Please select all medications that you are currently taking:

- | | | | | |
|---|--|-------------------------------------|--|---|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Analgesics | <input type="checkbox"/> Antacids | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Antihistamines | <input type="checkbox"/> Anti-Inflammatory | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Aspirin | <input type="checkbox"/> Birth Control |
| <input type="checkbox"/> Blood Pressure | <input type="checkbox"/> Bone Density | <input type="checkbox"/> Cancer | <input type="checkbox"/> Cholesterol | <input type="checkbox"/> Daily Vitamins |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestion | <input type="checkbox"/> Heart | <input type="checkbox"/> Muscle Relaxers | |
| <input type="checkbox"/> OTC | <input type="checkbox"/> Pain | <input type="checkbox"/> Steroids | <input type="checkbox"/> Thyroid | |

Allergies

Please select all items that you are allergic to:

- | | | | |
|-------------------------------|-------------------------------------|-----------------------------------|--|
| <input type="checkbox"/> None | <input type="checkbox"/> Other | <input type="checkbox"/> Chemical | <input type="checkbox"/> Environmental |
| <input type="checkbox"/> Food | <input type="checkbox"/> Medication | <input type="checkbox"/> Seasonal | |

Social History

Please answer the following questions:

- | | | | | |
|----------------------------------|---------------------------------|----------------------------------|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Married | <input type="checkbox"/> Single | <input type="checkbox"/> Widowed | <input type="checkbox"/> Divorced | <input type="checkbox"/> Separated |
|----------------------------------|---------------------------------|----------------------------------|-----------------------------------|------------------------------------|
- Do you have any children? Yes No If yes, how many? _____
- Do you use: Tobacco Alcohol Coffee

Skocik Chiropractic

**Insurance Information for
Motor Vehicle Accident / Worker's Compensation**

Insurance Name: _____

Address: _____

City: _____ State _____ ZIP _____

Claim Adjuster: _____

Phone: _____

Fax: _____

Claim#: _____

Date of Accident _____

Attorney Name: _____

Address: _____

City: _____ State _____ Zip _____

Phone: _____

Fax: _____

Office Use: Date Verified _____

Verified by _____

PIP Coverage ___ Y ___ or ___ N ___

Amount _____

Deductible _____

ASSIGNMENT OF INSURANCE BENEFITS, RELEASE, & DEMAND

I, the undersigned patient/insured knowingly, voluntarily and intentionally assign the rights and benefits of my automobile Insurance, also known as Personal Injury Protection (P.I.P.), and Medical Payments policy of insurance to the above health care provider. I understand it is the intention of the provider to accept this assignment of benefits in lieu of demanding payment at the time services are rendered and that this document will allow the provider to file suit against an insurance company for payment of the insurance benefits. This assignment of benefits includes overdue interest payments and any potential claim for common law or statutory bad faith. If the insurer disputes the validity of this assignment of benefits then the insurer is instructed to notify the provider in writing within five (5) days of receipt of this document. Failure to inform the provider shall result in a waiver by the insurer to contest the validity of this document. The undersigned directs the insurer to pay the health care provider directly without including the patient's name on the check.

The insurer is directed by the provider and the undersigned to not issue any checks or drafts in partial settlement of a claim that contain or are accompanied by language releasing the insurer or its insured/patient from liability unless there has been a prior written settlement agreed to by the health provider and the insurer as to the amount payable under the insurance policy or contract. The provider hereby objects to any reductions or partial payments. Any partial or reduced payment, regardless of the accompanying language, issued by the insurer and deposited by the provider shall be done so under protest, at the risk of the insurer, and the deposit shall not be deemed a waiver, accord, satisfaction, discharge, settlement or agreement by the provider to accept a reduced amount as payment in full. The insurer is hereby placed on notice that this provider reserves the right to seek the full amount of the bills submitted.

In the event the subject medical benefits are disputed by the insurer for any reason the undersigned hereby instructs the insurer to set aside any amount disputed (i.e., to escrow the money) and not pay the disputed amount to anyone, including myself, or any entity until the dispute is resolved. The insurer is instructed to immediately explain in writing to the above provider of any dispute. If the insurer schedules a defense examination or examination under oath (herein after "EUO") the insurer is hereby INSTRUCTED to send a copy of said notification to this provider. The provider or the provider's attorney is expressly authorized to appear at any EUO or IME set by the insurer. The health care provider is not the agent of the insurer or the patient for any purpose.

This assignment applies to both past and future medical expenses and is valid even if undated. A photocopy of this assignment is to be considered as valid as the original.

I agree to pay any applicable deductible, co-payments, for services rendered after the policy of insurance exhausts, and for any other services unrelated to the automobile accident.

The health care provider is given the power of attorney to endorse my name on any check for services rendered by the above provider and to request any statements or examinations under oath the patient provided to any insurer.

Release of information: I hereby authorize this provider to: furnish an insurer, an insurer's intermediary, the patient's other medical providers, and the patient's attorney via mail, fax, or email, with any and all information that may be contained in the medical records; to obtain insurance coverage information in writing (declaration sheet) and telephonically from the insurer; request from the insurer all EOBs for all providers and non-redacted PIP payout sheets; obtain any statements the patient provided to the insurer, obtain copies of all medical records, including but not limited to, documents, reports, scans, notes, bills, opinions, X-rays, IMEs, and MRIs, from any other medical provider or any insurer. The insurer is directed to keep the patient's medical records from this provider private and confidential and the insurer is not authorized to provide these medical records to anyone without the patient's and the provider's prior express written permission. The provider is permitted to produce my medical records to its attorney in connection with any pending lawsuits.

Demand: Demand is hereby made for the insurer to pay all bills within 30 days without reductions and to mail the latest non-redacted PIP payout sheet and the insurance coverage declaration sheet to the above provider within 15 days.

Certification: I certify that: I have read and agree to the above; I have not been solicited or promised anything in exchange for receiving health care; I have not received any promises or guarantees from anyone as to the results that may be obtained by any treatment or service; I agree the provider's prices for medical services, treatment and supplies are reasonable and customary.

Caution: Please read before signing. If you do not completely understand this document please ask us to explain it to you. If you sign below we will assume you understand and agree to the above.

Patient's Name: _____

Patient's Signature

Date: _____

(Please Print)

(If patient is a minor, signature of parent/guardian)

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 or Representative

Date

Printed Name

INFORMED CONSENT FORM

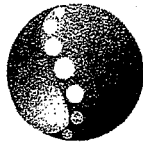
I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of physical therapy and diagnostic X-rays, on me (or on the patient named below, for whom I am legally responsible) by the doctor of chiropractic named below and/or other 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 than 24 hours notice.

Thank you for your cooperation.

Patient Signature

Date