Date: ____________ I.D.#: ________

Edward M. Horvath, D.C.
1060 S. Valley Forge Road
Lansdale, PA 19446-4526

Patient Information

Today's Date: ______________________________

Name (First, M.I., Last): ______________________________

Date of Birth: ______________ Age: ______ Email Address: ______________

Address: ______________________________

City: ______________ State: ________ Zip Code: ______________

Home #: ______________ Cell #: ______________ Work #: ______________

Contact Preference: __Email __ Home Phone __Cell Phone

Would like to receive appointment reminders via text? _____ If yes, cell phone carrier__________________

Marital Status: __ Single __ Married __ Divorced __ Widowed __ Significant Other

Name of Spouse: ______________ Number and ages of children: ______________

Occupation: ______________ Place of work: ______________

Referred by: ______________________________

Have you ever had chiropractic care? __ Yes __ No If yes, when and where: ______________

Is your visit in reference to an accident? __ Yes __ No If yes: Date of Accident: ______________

Was it: __ Worker's Comp __ Automobile __ Personal Injury

Chiropractic services will be paid: __ Cash __ Health Insurance __ Auto Insurance __ Worker's Comp.

(Please have your card(s)/information available for copying purposes)

Do you want us to file your insurance? __ Yes __ No

Name of Health Insurance Carrier and I.D.#: ______________________________

Name of person responsible for your account: ______________________________

Health and accident policies are an arrangement between the carrier and the patient which are usually designated to offset a large portion of the total cost. This office will prepare any necessary reports and forms to assist in making collections from the insurance company to the patient, or any amount authorized to be paid directly to this office and will be credited to the patient's account. It should be understood that all services furnished are charges directly to the patient who is personally responsible for payment.

I hereby certify that the answers given on this form are accurate to the best of my knowledge and understand it is my responsibility to inform this office of any changes to my health/personal information.

Patient/Guardian Signature: ______________________________

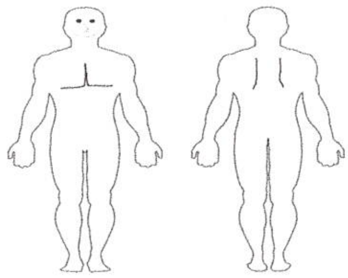
Date: ______________________

Name: ______________________________ Date: ______________ I.D. #: __________

Confidential Case History Record

Please fill out the following form in as much detail as possible. Please print. If you need assistance please ask.

Place an "X" on the area(s) that are causing you pain with a letter to describe it.



Front View **Back View**

A=Ache
B=Burning
N=Numbness
P=Pins, Needles
S=Sharp, Stabbing
T=Tightness, Loss of Motion
O=Other:______________

Pain Scale: Please grade your intensity of pain.

0 1	2 3 4	5 6 7	8 9 10
None	Little	Medium	Severe

Major complaints and symptoms-please be as specific as you can : ______________________________

____

____

Secondary complaints and symptoms: ______________________________

____

How do you believe your problem /pain began: ______________________________

____

When did you first notice this problem/pain: ______________________________

Have you lost any work: __________ Day and date you last worked: ______________________________

Have you ever had this condition before or a similar condition: ________ When: ______________________________

What positions/activities aggravate your condition? ______________________________

What positions/activities relieve your condition? ______________________________

Have you been treated by a Medical Physician for this ailment? ________ Where? ______________________________

Describe the type of treatment: ______________________________

Diagnosis of previous physician: ______________________________

Length of time under care: ______________________ Results: ______________________________

Are you allergic to anything you are aware of (Medication, Seasonal, Foods etc)? ______________________________

Are you presently taking any medication (aspirin included)? Yes _____ No _____

If yes, please list them: ______________________________

____

Name: ______________________ Date: ______________ I.D. #:__________

Do you take vitamin? Yes ____ No ____ If yes, please list them: ______________________

Have you ever been in any accidents-auto, fall down stairs, fall from ladder etc. (even as a child)? ______________

When? ______________________

Have you ever broken any bones (fractured)? _______ Any dislocations? _______

If yes, please list: ______________________

What operation(s) have you had? ______________________ Year __________

______________________ Year __________

______________________ Year __________

Have you been treated for any health condition by a physician in the past year? If yes, please explain: ______________

____

Do you have any health problems not listed? ______________________

Habits: (Please check)

Cigarettes: _____ Quantity:______________ Alcohol: _____ Quantity:______________

Coffee: _____ Quantity:______________ Tea: _____ Quantity:______________

Have you lost or gained weight in the past year? ______________________

Family Health History:	Father's Side	Mother's Side
Cancer	_______	_______
Arthritis	_______	_______
Diabetes	_______	_______
Heart Disease	_______	_______
Congenital Spinal Defects	_______	_______
Other:	_______	_______
	_______	_______

I understand and agree that health and accident insurance policies are an agreement between the insurance carrier and myself, and 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 my care and treatment, any fees for professional services rendered me will be immediately due and payable.

Patient/Guardian Signature: ______________________ Date: ______________

Patient Name:______________________ I.D.#: __________ Date: __________

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Review of Systems

Please place a check beside any of the following symptoms if you have experienced them recently or have concerns about them.
If you do not understand something, place a question mark by it. Your doctor will discuss any positive results with you.

A. General/Constitutional:

____ Fever, chills or sweat
____ Recent loss of appetite
____ Fatigue
____ Recent unexpected weight loss

B. Eyes:

____ Blurred or double vision
____ Eye pain or irritation
____ Eye discharge
____ Failing vision
____ Sensitivity to light

C. Ears, Nose, Throat:

____ Earache
____ Ringing in ears
____ Decreased hearing
____ Difficulty swallowing
____ Frequent nose bleeds
____ Frequent sore throat
____ Prolonged hoarseness
____ Sinus trouble or congestion

D. Cardiovascular:

____ Chest pain
____ Fainting spells
____ Palpitation (fast, irregular heart)
____ Shortness of breath with exertion
____ Swollen ankles

E. Respiratory:

____ Chronic cough
____ Chronic shortness of breath
____ Chronic wheezing
____ Coughing up blood
____ Excessive phlegm

F. Gastrointestinal:

____ Persistent nausea/vomiting
____ Diarrhea
____ Constipation
____ Change in appearance of stool
____ Chronic abdominal pain
____ Bloody or very black stool
____ Jaundice (yellow skin)

G. Genitourinary-*Female:*

____ Loss of control of your urine
____ Painful urination
____ Blood in urine
____ Increased frequency of urination
____ Have your periods stopped
____ Do you have excessive flow, pain that disrupts your life
____ Unusual vaginal discharge
____ Genital sores
____ Nipple discharge
____ Breast mass/tenderness

H. Genitourinary-*Male:*

____ Painful urination
____ Blood in urine
____ Increased frequency of urination
____ Urinating more than twice a night
____ Loss of control of your urine
____ Difficulty getting/maintaining erection
____ Decreased desire for sexual intercourse

I. Musculoskeletal:

____ Back pain
____ Joint pain
____ Swelling in joints
____ Muscle cramping
____ Muscle weakness
____ Muscle stiffness
____ Arthritis

J. Skin:

____ Skin rashes
____ Itching
____ Chronic dry skin
____ Suspicious moles/skin abnormalities

K. Blood/Lymphatic:

____ Excessive bleeding or bruising
____ Swollen glands in neck, armpits or groin

L. Neurologic:

____ Headache
____ Unable to move parts of your body at times
____ Weakness
____ Numbness/tingling sensation
____ Seizures, convulsions
____ Fainting spells
____ Tremor/hands shaking
____ Dizziness/vertigo

M. Psychological:

____ Feeling depressed, sad
____ Memory loss
____ Difficulty concentrating
____ Phobias/unexplained fears
____ No pleasure in life anymore

N. Endocrine:

____ Cold or heat intolerance
____ Excessive appetite
____ Excessive thirst and urination
____ Significant weight change

O. Allergic/Immunologic:

____ Hives
____ Hay fever
____ Getting many infections

P. Family History of:

Mother:		Father:	
____	Hypertension	____	Hypertension
____	Heart Disease	____	Heart Disease
____	Diabetes	____	Diabetes
____	Cancer	____	Cancer
____	Arthritis	____	Arthritis

Q. Is there anything you would like the doctor to be aware of?:

____
____
____
____
____
____

Patient/Guardian Signature: ______________________ Date: ________

Informed Consent to Chiropractic Care

Chiropractic Healthcare Center of Lansdale
Edward M. Horvath, D.C.
1060 S. Valley Forge Road
Lansdale, PA 19446-4526
(215) 393-8999

Patient Name: ____ Birthdate: ____________ I.D. #:__________

Please discuss any questions or concerns with Dr. Horvath before signing this consent.

I hereby request and consent to the performance of chiropractic adjustments and other chiropractic procedures, including various modes of adjunctive therapy by Dr. Horvath.

I have had the opportunity to discuss with the doctor the purpose and benefits of chiropractic adjustments and other treatments. Alternatives to treatment have been reviewed. I understand that results are not guaranteed.

Though chiropractic adjustments and treatments are usually beneficial and seldom cause any problem, I understand and am informed that 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 treatment which the doctor feels at the time, based upon the facts then known to him, is in my best interest.

I understand that chiropractic is not an exact science and therefore cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the chiropractic treatment that I have requested and authorized.

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

____ ______________________________
Please Print Name of Patient Date

____
Signature

____ ______________________________
Doctor's Signature Date

Chiropractic Healthcare Center of Lansdale
Edward M. Horvath, D.C.
1060 S. Valley Forge Road   Lansdale, PA 19446-4526

Consent for Use or Disclosure of Health Information
Our Privacy Policy

We are very concerned with protecting your privacy. While the law requires us to give you this disclosure, please understand, that we have, and always will respect the privacy of your health information.

There are several circumstances in which we may have to disclose your health care information.

We may have to disclose your health information to another health care provider or hospital if it is necessary to refer you to them for diagnosis, assessment, or treatment of your health condition.

We may have to disclose your health information and billing records to another party if they are potentially responsible for the payment of your services.

We may need to use your health information within our practice for quality control or other operational purposes.

Your Right to Limit Uses or Disclosure

You have the right to request that we do not your health information to specific individuals, companies or organizations. If you would like to place any restrictions on the use of disclosure of your health information, please let us know in writing. We are not required to agree to your restrictions. However, if we agree to your restrictions the restriction is binding on us.

Your Right to Revoke Your Authorization

You may revoke your consent to us at any time, however, your revocation must be in writing. We will not be able to honor your revocation request if we have already released your health information before we receive your request to revoke your authorization. If your were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your health information if they decide to contest any of your claims.

______________________________ Printed Patient/Guardian Name

______________________________ Authorizied Facility Representative

______________________________ Patient/Guardian Signature

______________________________ Date

______________________________ Date