

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 email? _____

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.

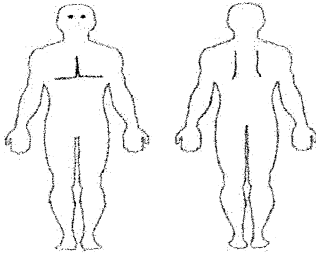
Patient/Guardian Signature: _____

Date: _____

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.



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

Front View Back View

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: _____

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

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:

- ☐ Hypertension
☐ Heart Disease
☐ Diabetes
☐ Cancer
☐ Arthritis

Father:

- ☐ Hypertension
☐ Heart Disease
☐ Diabetes
☐ Cancer
☐ 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

Authorized Facility Representative

Patient/Guardian Signature

Date

Date