Pivonka Chiropractic, P.C.

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1355 S. Higley Rd. #102 Gilbert AZ 85296
(480) 892-0022

Patient Application for Treatment

Today's Date: ____________

Name: ____How would you like to be addressed? ____________

Date of Birth: _____/______/______ Age: ________ Gender: Male ______ Female:______

Your Address: ________________________________ City: ____________ State: _____ Zip: __________

SS# ________________Home # ________________ Wk# _________________ Cell# ________________

Your Occupation: _____________________________ Emergency Contact: __________________________

Marital Status: S M W D How Many Children do you have? _____ What are their ages?___________

Have you had previous Chiropractic care? Y N Name of Chiropractor:______________________

How long ago did you see your last Chiropractor? ___________________________________

The purpose or reason for this appointment? ____

Do you drink alcoholic beverages? Y N How Often? ____________________

Do you smoke? Y N How much? ____________________________________

Do you exercise Y N How often? ________________________ Type?______________________

Have you ever suffered from or been diagnosed as having:(Circle yes or no for each)

Y N *Broken or Fractured Bones
Y N Circulatory Problems
Y N *Rheumatoid Arthritis
Y N Seizures/Convulsions
Y N A Congenital Disease
Y N Excessive Bleeding
Y N High/Low Blood Pressure
Y N * Diabetes
Y N Fatigue
Y N Thyroid Problems
Y N *Osteoarthritis
Y N Epilepsy
Y N Pacemaker
Y N Strokes
Y N *Cancer
Y N Ulcers
Y N Ruptures
Y N Bladder Problems
Y N Female Problems
Y N Dizziness/ Fainting
Y N Eating Disorder
Y N Alchoholism
Y N Drug addiction
Y N HIV Positive
Y N Gall Bladder
Y N *Head Problems
Y N Depression
Y N Tumors
Y N Heart Disease

*Explanation: ____
____
____

Current Medications

Name of Med. and dose____

Name of Med. and dose____

Name of Med. and dose____

Pain Medications ____ Number per week __________

For Doctor's use only

oGeneral

oNDRA

Drug Allergies:

oSee Meds Addendum

Trauma History

This is an extremely important aspect of your patient history. It helps us determine when and how your problem began. Please take the time to think back and with the best detail you can give us the types of traumas you have had throughout your life, even back to childhood falls.

Auto accident history
Almost every person has been involved in an automobile accident. Even if you think you were not injured in an accident **please list all you have had, even if they were 5 miles per hour.**

MVA #1: Type: rollover, side-impact, head-on, rear-end Approx. speed of car your car: _______
Chiropractic Treatment after accident Y / N Approx. speed of other car: ________
Year of Accident: ___________ Was the accident your fault Y N
Type of vehicle your were in _______________ other vehicle type _________________

MVA #2: Type: rollover, side-impact, head-on, rear-end Approx. speed of car your car: _______
Chiropractic Treatment after accident Y / N Approx. speed of other car: ________
Year of Accident: ___________ Was the accident your fault Y N
Type of vehicle your were in _______________ other vehicle type _________________

MVA #3: Type: rollover, side-impact, head-on, rear-end Approx. speed of car your car: _______
Chiropractic Treatment after accident Y / N Approx. speed of other car: ________
Year of Accident: ___________ Was the accident your fault Y N
Type of vehicle your were in _______________ other vehicle type _________________

Athletic Fall/ Work Slips or Falls / Childhood falls

If you have played athletics please list a few of the impacts you have sustained, if they were memorable. This includes all forms of activities from dance to cheerleading, contact sports, etc… If you have had stresses or strains at work list them here too. Think back to your childhood and remember any big falls you took, like off your bike, out of a tree, off a horse, etc…

Fall #1 ____ approx. date ________

Fall #2 ____ approx. date ________

Fall #3 ____approx. date ________

Past Surgeries that may effect your care

Surgery #1 ____approx. date ________

Surgery #2 ____approx. date ________

Surgery #3 ____approx. date ________

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Patient History

1. What is your **main complaint**? ____

2. On the scale below, please circle the severity of your **main complaint** (At it's worst)

None		Slight		Mild		Moderate		Severe	
1	2	3	4	5	6	7	8	9	10

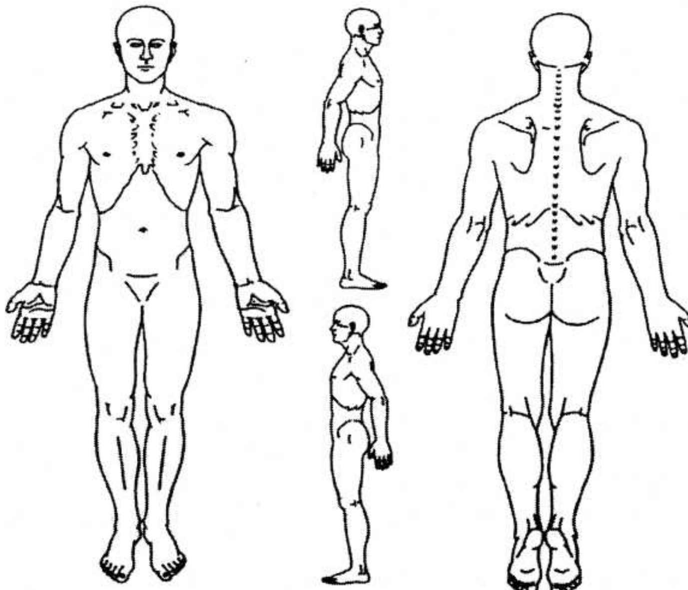
3. On the scale below please circle the **percentage of time** your experience you **main complaint:**

	Occasional			Intermittent			Frequency		Constant	
0	10	20	30	40	50	60	70	80	90	100

4. How **long** have you been experiencing your **main complaint?** ________

5. **On the diagram below, please show** where **you are experiencing** all **of your present complaints using the following letters:**

A: ache B: burning pain C: cramping D: dull ache R: throbbing pain N: numbness T: tingling



When do you notice it most? AM PM

How long does it last? _______Minutes ________Hours

What makes it feel better? ____

What makes it feel worse? ____

Have you ever had this problem in the past? Yes No

Have you lost time from work because of it? Yes No

Dates? _____________ to ______________

Do you have pain and/ or difficulty performing any of the following activities: (Check)

Personal Care _______

Lifting _______

Reading _______

Concentrating _______

Work _______

Driving _______

Sleeping _______

Recreation _______

Walking _______

Sitting _______

Standing _______

Social Life _______

PAYMENT/OFFICE POLICIES:

1. **Payment for all services rendered are due at the completion of your first office visit, *regardless of insurance coverage*. If you have questions or financial concerns please speak directly to the doctor.**

2. **Please make sure we have a copy of your insurance card if applicable.**

3. **WE TYPICALLY DO NOT ADJUST PATIENTS ON THEIR FIRST VISIT. Please advise the doctor if you have any concerns regarding this matter.**

4. **During your second and third consultations, the doctor will explain your findings and options for care. Financial arrangements and any insurance coverage will also be discussed at these times.**

Assignment and Release:

I authorize the release of information to family physicians and employer.
I authorize the release of information to insurance companies.
I authorize the taking of photographs and x-rays to be used for treatment purposes.
I authorize the performance of other diagnostic and therapeutic procedures for treatment purposes.
I authorize my insurance benefits to be paid directly to:

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I acknowledge that I am financially responsible for all services rendered to me in this office.
I also understand that if I terminate my care and treatment, any fees for professional services rendered to me will be due immediately, unless other financial arrangements have been made.

Signature:____ **Date:**______________

Acknowledgement of Receipt of
Notice of Privacy Practices and
Pivonka Chiropractic, P.C. Health Care Authorization Form

You May Refuse to Sign This Acknowledgement

I, ____, have received a copy of this office's Notice of Privacy Practices and Health Care Authorization Form

____
Signature

____
Date

For Office Use Only
We attempted to obtain written acknowledgement, but acknowledgement could not Be obtained because: ( ) Individual refused to sign ( ) Communications barrier
( ) Emergency Situation ( ) Other __________________