Mr. \ Mrs. \ Ms. \ Miss

First Name: _____ M.I.:____ Last Name: _____

What Do You Prefer To Be Called: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

SS #: _____ Sex: _____ Single \ Married \ Divorced \ Widow

Spouse Name: _____ Email: _____

Home #: _____ Cell #: _____ Other #: _____

Emergency Contact: _____ Relationship: _____ T: _____

How did you hear about us? _____

Who can we thank for the referral? _____

Who is your Primary Care Doctor? _____

Do you have Medicare? ☐ Yes ☐ No

Secondary Insurance or Supplement to Medicare: _____

Primary Insurance (Besides Medicare): _____

– Please hand the front desk all of your insurance cards –
– They will copy them & return back to you –

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Insurance verification and authorization is not a guarantee of payment. I understand that I may be responsible for any balance that is not paid by insurance. I authorize Glover Chiropractic Clinic to release any information regarding my treatment to any insurance company in effort to receive reimbursement for services provided. I authorize the use of this signature on all insurance submissions.

_____	_____	_____
Signature	Date	Parent (if patient is a minor)

The US Government is now requiring that we supply them with the following information:
Ethnicity: □ Hispanic or Latino □ Not Hispanic or Latino
Race: □ White □ American Indian/Alaskan Native □ Asian □ African American □ Native Hawaiian/Pacific Islander
Preferred Language: □ English □ Spanish □ French □ German □ Italian □ Mandarin □ Cantonese □ Tagalog □ Japanese
Have you ever been diagnosed with either of the following? □ Asthma □ Diabetes

Anyone in your immediate family with any of the following:
☐Rheumatoid Arthritis ☐ Diabetes ☐ Lupus ☐ Cancer ☐ ALS
☐ Heart Problems

For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present		Past	Present		Past	Present	
□	□	Headaches	□	□	High Blood Pressure	□	□	Diabetes
□	□	Neck Pain	□	□	Heart Attack	□	□	Excessive Thirst
□	□	Upper Back Pain	□	□	Chest Pains	□	□	Frequent Urination
□	□	Mid Back Pain	□	□	Stroke	□	□	Smoking/Tobacco Use
□	□	Low Back Pain	□	□	Angina	□	□	Drug/Alcohol Dependance
□	□	Shoulder Pain	□	□	Kidney Stones	□	□	Allergies
□	□	Elbow/Upper Arm Pain	□	□	Kidney Disorders	□	□	Depression
□	□	Wrist Pain	□	□	Bladder Infection	□	□	Systemic Lupus
□	□	Hand Pain	□	□	Painful Urination	□	□	Epilepsy
□	□	Hip Pain	□	□	Loss of Bladder Control	□	□	Dermatitis/Eczema/Rash
□	□	Upper Leg Pain	□	□	Prostate Problems	□	□	HIV/AIDS
□	□	Knee Pain	□	□	Abnormal Weight Gain/Loss			
□	□	Ankle/Foot Pain						
			□	□	Loss of Appetite	**For Females Only**		
□	□	Jaw Pain	□	□	Abdominal Pain	□	□	Birth Control Pills
□	□	Joint Pain/Stiffness	□	□	Ulcer	□	□	Hormonal Replacement
□	□	Arthritis	□	□	Hepatitis	□	□	Pregnancy
□	□	Rheumatoid Arthritis	□	□	Liver/Gall Bladder Disorder			
□	□	Cancer	□	□	General Fatigue			
□	□	Tumor	□	□	Muscular Incoordination			
□	□	Asthma	□	□	Visual Disturbances			
□	□	Chronic Sinusitis	□	□	Dizziness			
□	□	Other:_____						

Please list any <u>medications</u> you are currently taking: _____

_____

_____

Please list any <u>supplements</u> you are currently taking: _____

_____

_____

Please list any <u>surgical</u> procedures you have had:_____

_____

_____

Do you have any <u>allergies</u> to medication/food/seasonal?
☐ No ☐ Yes, Please list: _____

What activities do you do during the day?

☐ Sit:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ Stand:	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ Computer Work	☐ Most of the day	☐ Half the day	☐ A little of the day
☐ On the phone	☐ Most of the day	☐ Half the day	☐ A little of the day

Please list any hobbies or activities you do outside of work: _____

_____

Any other hospitalizations not previously mentioned?
☐ No ☐ Yes, Please list: _____

Any other past significant trauma?
☐ No ☐ Yes, Please list: _____

Please circle any of the following symptoms you have had or Check NONE

		NONE
CONST	FEVER CHILLS WEIGHT LOSS WEIGHT GAIN	
EYES	GLASSES CONTACTS VISION CHANGES	
EARS	HEARING AIDS DIFFICULT HEARING LOSS OF HEARING	
NOSE	SINUS PAIN	
THROAT	DIFF. SWALLOWING SORE THROAT	
MOUTH	MOUTH PAIN	
CARDIO	CHEST PAIN PALPITATIONS	
RESP	SHORTNESS OF BREATH COUGH	
GI	ABD PAIN NAUSEA VOMITTING DIARRHEA CONSTIPATION ACID REFLUX	
GU	CHANGE IN FREQUENCY OR PAIN WITH URINATION	
SKIN	RASH WOUNDS	
NEURO	SEIZURE FAINTING NUMBNESS TINGLING WEAKNESS DIZZINESS	
H	DEPRESSION CHANGE IN APPETITE CHANGE OF SLEEP	
ENDOCRINE	DRY SKIN	

I affirm that the information I have given is correct to the best of my knowledge. The information I have provided will remain confidential, and I understand that it is my responsibility to inform this office of any changes in my medical status.

PRINT PATIENT NAME _____ SIGNATURE _____ DATE _____

INFORMED CONSENT

I understand and am informed that, as in all health care, in the practice of chiropractic there is a small inherent risk of injury which includes but is not limited to, muscle strains, sprains, fractures, dislocation, intervertebral disc injury, and cardiovascular accident. I understand that Dr. Jeffrey N. Glover will not be able to anticipate all potential complications, but will rely on clinical expertise and judgment to determine the correct course of treatment, which will be in my best interests considering all known facts. I understand that results are not guaranteed and that I have the opportunity to discuss the purposes and risks associated with all recommended evaluation and treatment procedures at any time.

I have read and understand the preceding statements and herby consent to voluntarily participate in orthopedic, neurologic and physical performance testing, as well as manipulative, and exercise/rehabilitation therapies as deemed appropriate by Dr. Jeffrey N. Glover. If at any time, I have further questions or decide not to continue to consent in treatment, I understand I have that right and it is my duty to notify my doctor.

_____	_____	_____
PRINT PATIENT NAME	SIGNATURE	DATE

If patient is a minor:

_____	_____	_____
PRINT PARENT/GUARDIAN NAME	SIGNATURE	DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided a copy of the Notice of Privacy Practices and that I have read them or declined the opportunity to read them and understand the Notice of Privacy Practices. I understand that this form will be placed in my patient chart and maintained for six years.

_____ _____

Patient Name (please print) Date

_____

Parent, Guardian or Patient's legal representative (please print)

_____

Signature

List below the names and relationship of people to whom you authorize Glover Chiropractic Clinic to release PHI.

_____ _____

_____ _____

_____ _____

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