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

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

Email: _____

Spouse Name: _____

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 –

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 ARE CURRENTLY HAVING 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.

_____ _____

_____ _____

_____ _____

Consent to Receive Text Message Appointment Reminders

By signing below, I authorize Glover Chiropractic Clinic to contact me by automated SMS text message for appointment reminders.

I understand that message/data rates may apply to messages sent by Glover Chiropractic Clinic under my cell phone plan.
My text/mobile phone number is: (_____) _____ Patient Initials: _____

I know that I am under no obligation to authorize Glover Chiropractic Clinic to send me text messages. I may opt-out of receiving these communications at any time by calling the Office @ 352-787-9995 or by responding STOP to 352-462-3935. Please allow 2-3 business days for processing.

I understand that text messaging is not a secure format of communication. There is some risk that individually identifiable health information or other sensitive or confidential information contained in such text may be misdirected, disclosed to, or intercepted by unauthorized third parties. Information included in text messages may include your first name, date/time of appointments, name of physician, and physician phone number, or other pertinent information.

By signing below, I indicate I am the primary user for the mobile phone number listed above, I accept the risk explained above and consent to receive text messages via automated technology from Glover Chiropractic Clinic to the phone number that I have provided.

Patient Name: _____

Signature: _____

Date: _____ Date of Birth: _____

Fax: Glover Chiropractic Clinic at (352) 787-9997
Attn: Medical Records

Mail: Glover Chiropractic Clinic
Attn: Medical Records
312 N 14th Street
Leesburg, FL 34748

Today's Date: _____

Patient's Name: _____

What symptoms/discomfort/pain/area of complaint brings you to the office **TODAY**?

1. _____

   How often do you experience **THESE** symptom(s)?
   ☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
   ☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

   How would you describe the type of pain?
   ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy
   ☐ Burning ☐ Shooting ☐ Stiff ☐ Sharp w/ Motion
   ☐ Shooting w/ Motion ☐ Stabbing w/ Motion ☐ Electric like
   ☐ Other: _____

   How are **THESE** symptom(s) changing with time?
   ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

   Using a scale from 0 – 10 (10 being the worst), how would you rate **THESE** symptom(s)? (Please Circle)
   0 1 2 3 4 5 6 7 8 9 10

2. _____

   How often do you experience **THESE** symptom(s)?
   ☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
   ☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

   How would you describe the type of pain?
   ☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy
   ☐ Burning ☐ Shooting ☐ Stiff ☐ Sharp w/ Motion
   ☐ Shooting w/ Motion ☐ Stabbing w/ Motion ☐ Electric like
   ☐ Other: _____

   How are **THESE** symptom(s) changing with time?
   ☐ Getting Worse ☐ Staying the Same ☐ Getting Better

   Using a scale from 0 – 10 (10 being the worst), how would you rate **THESE** symptom(s)? (Please Circle)
   0 1 2 3 4 5 6 7 8 9 10

3. _____

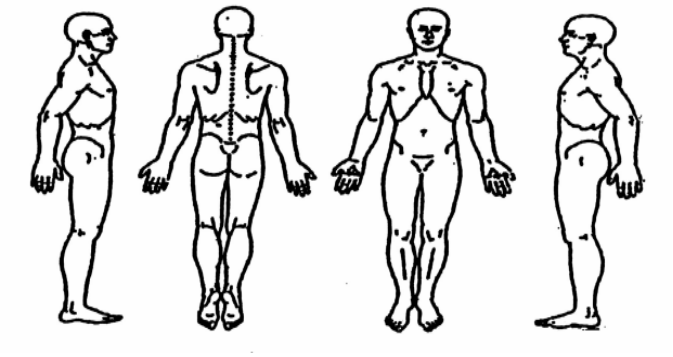
How often do you experience **THESE** symptom(s)?
☐ Constantly (76-100% of the time) ☐ Frequently (51-75% of the time)
☐ Occasionally (26-50% of the time) ☐ Intermittently (1-25% of the time)

How would you describe the type of pain?
☐ Sharp ☐ Numb ☐ Dull ☐ Tingly ☐ Diffuse ☐ Achy
☐ Burning ☐ Shooting ☐ Stiff ☐ Sharp w/ Motion
☐ Shooting w/ Motion ☐ Stabbing w/ Motion ☐ Electric like
☐ Other: _____

How are **THESE** symptom(s) changing with time?
☐ Getting Worse ☐ Staying the Same ☐ Getting Better

Using a scale from 0 – 10 (10 being the worst), how would you rate **THESE** symptom(s)? (Please Circle)
0 1 2 3 4 5 6 7 8 9 10

Please mark the area(s) of complaint below:



Within the last week, how much (percentage of the day) has pain interfered with your activities (work, social activities, household chores, hobbies, etc)?
☐ Not at all (0%) ☐ A little bit (10-30%) ☐ Moderately (40-60%) ☐ Quite a bit (70-90%)
☐ Extremely (100%)

Have you seen anyone **RECENTLY** for your **CURRENT** symptoms? ☐ Yes ☐ No
If YES, who have you seen for these symptoms?
☐ Chiropractor (Not Dr. Glover) ☐ Neurologist ☐ Primary Care ☐ ER Physician
☐ Orthopedist ☐ Massage Therapist ☐ Physical Therapist ☐ Urgent Care
☐ Other: _____

How long have you had these symptoms (how long have you had your most **RECENT** flair-up)?

_____

What caused your symptoms (what caused your most **RECENT** flair-up)?
☐ Unknown ☐ From a recent fall, when: _____ ☐ Auto Accident
☐ Playing sports (golf, pickleball, etc) ☐ From working out ☐ From working in yard
☐ From cleaning the house ☐ From lifting heavy objects
☐ Traveling long distance ☐ Other: _____

Do you consider their symptoms to be severe? ☐ Yes ☐ Yes, at times ☐ No

What activities aggravate (worse) your symptoms? _____

What activities alleviate (better) your symptoms? _____

What concerns you most about your symptoms?
☐ It could be serious ☐ It is affecting sports (golf, pickleball, etc) ☐ It isn't going away
☐ It is affecting sleep ☐ It is affecting hobbies ☐ It is affecting my focus
☐ It is affecting work ☐ It is affecting social life ☐ It is getting worse
☐ It is affecting my normal daily activities ☐ Other: _____

Have you had any x-rays\MRIs\CTs taken that are related to your symptoms?
☐ Yes ☐ No
If yes,
When: _____

Where: _____

What doctored ordered them? _____

What did the doctor say about the findings/results? _____

Height: _____ Weight: _____

What is your occupation: _____

How would you rate your overall health?
☐ Excellent ☐ Very Good ☐ Good ☐ Fair ☐ Poor

Have you been to a chiropractor before?
☐ Yes ☐ No
If yes, when is the last time you had chiropractic treatment?

_____

How did you feel after that chiropractic treatment?

_____

What type of treatment did they do at the chiropractor's office?

_____

_____

Anything else you would like to talk to Dr. Glover about? _____

_____

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

NECK PAIN AND DISABILITY INDEX

Patient Name:_____ Date:_____/_____/_____

Please read instructions carefully.

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage everyday life. Please read all statements in each section and then mark the box that most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is worse than imaginable at the moment.

SECTION 2 - PERSONAL CARE (washing, dressing, etc.)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed. I wash with difficulty and stay in bed.

SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can lift very light objects.
- ❑ I cannot lift or carry anything at all.

SECTION 4 - READING

- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with light pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can't read as much as I want to because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

SECTION 5 - HEADACHES

- ❑ I have no headache at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 - CONCENTRATION

- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have a fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

SECTION 7 - WORK

- ❑ I can do as much work as I want.
- ❑ I can do only my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly work at all.
- ❑ I can't do any work at all.

SECTION 8 - DRIVING

- ❑ I can drive without any neck pain.
- ❑ I can drive as long as I want with slight neck pain.
- ❑ I can drive as long as I want with moderate neck pain.
- ❑ I can hardly drive at all because of severe neck pain.
- ❑ I can't drive at all.

SECTION 9 - SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❑ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ❑ My sleep is moderately disturbed (3-5 hrs. sleepless).
- ❑ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 - RECREATION

- ❑ I am able to engage in all my recreational activities with no neck pain.
- ❑ I am able to engage in all my recreational activities with some neck pain.
- ❑ I am able to engage in most, but not all of my usual recreational activities because of neck pain.
- ❑ I am able to engage in a few of my usual recreational activities because of neck pain.
- ❑ I can hardly do any recreational activities because of neck pain.
- ❑ I can't do any recreational activities at all.

NECK PAIN SCALE

Rate the severity of your **Neck Pain** by indicating on the following scale.

Absence I----------I Extreme

LOW BACK PAIN AND DISABILITY INDEX (REVISED OSWESTRY)

Patient Name: _____ Date: _____/_____/_____

Please read instructions carefully.
This questionnaire has been designed to give the doctor information as to how your low back pain has affected your ability to manage everyday life. Please read all statements in each section and mark the box which most closely describes your problem.

SECTION 1 - PAIN INTENSITY

- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain is moderate and does not vary much.
- ❑ The pain comes and goes and is very severe.
- ❑ The pain is severe and does not vary much.

SECTION 2 - PERSONAL CARE

- ❑ I do not have to change my way of washing or dressing to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes some pain.
- ❑ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ❑ Washing and dressing increases the pain and I find it necessary to change my way of doing it.
- ❑ Because of the pain, I am unable to do some washing and dressing without help.
- ❑ Because of the pain, I am unable to do any washing or dressing without help.

SECTION 3 - LIFTING

- ❑ I can lift heavy objects without any extra pain.
- ❑ I can lift heavy objects, but it gives extra pain.
- ❑ Pain prevents me from lifting heavy objects off the floor.
- ❑ Pain prevents me from lifting heavy objects off the floor but I can manage if they are conveniently positioned on a table.
- ❑ Pain prevents me from lifting heavy objects but I can manage light to medium objects.
- ❑ I can only lift very light objects at the most.

SECTION 4 - WALKING

- ❑ I have no pain on walking.
- ❑ I have some pain but it does not increase with distance.
- ❑ I cannot walk more than one mile without increasing pain.
- ❑ I cannot walk more than 1/2 mile without increasing pain.
- ❑ I cannot walk more than 1/4 mile without increasing pain.
- ❑ I cannot walk at all without increasing pain.

SECTION 5 - SITTING

- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting more than one hour.
- ❑ Pain prevents me from sitting more than half an hour.
- ❑ Pain prevents me from sitting more than 10 minutes.
- ❑ I avoid sitting because it increases pain.

SECTION 6 - STANDING

- ❑ I can stand as long as I want without pain.
- ❑ I have some pain on standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer than 1/2 hour without increasing pain.
- ❑ I cannot stand longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain.

SECTION 7 - SLEEPING

- ❑ I get no pain in bed.
- ❑ I get pain in bed but it does not prevent me from sleeping well.
- ❑ Pain reduces my normal sleep by 1/4 each night.
- ❑ Pain reduces my normal sleep by 1/2 each night.
- ❑ Pain reduces my normal sleep by 3/4 each night.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 - SOCIAL LIFE

- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ My social life is unaffected by pain apart form limiting more energetic interests.
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 9 - DRIVING / RIDING IN CAR, ETC.

- ❑ I get no pain while traveling.
- ❑ I get some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I get extra pain while traveling but it does not compel me to seek alternate forms of travel.
- ❑ I get extra pain while traveling which compels me to seek alternate forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

SECTION 10 - CHANGING DEGREE OF PAIN

- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better or worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

LOW BACK PAIN SCALE

Rate the severity of your **Low Back Pain** by indicating on the following scale.

Absence I----------I Extreme