

PERSONAL HISTORY

Today's Date: _____

Name: _____ Email Address: _____

Address: _____ City: _____ State/Zip _____

Phone: _____ Cell: _____ Social Security #: _____

Birthdate: _____ Age: _____ Sex: Male Female Height: _____ Weight: _____

Are you? Married Single Widowed Divorced Separated Spouse's Name: _____

Business/Employer: _____ Work Phone: _____

Address: _____ City: _____ State/Zip _____

You are responsible for your bill. How will you pay? If health insurance, please provide card

Health Insurance Self Pay Spouse Medicare Worker's Compensation Auto Insurance

CURRENT HEALTH CONDITION

Reason For Your Visit: _____

When did your symptoms begin? _____

If you are experiencing pain, it: Comes and goes Is constant It travels or is radiating

Feels sharp Dull Throbbing Aching Shooting Burning Cramping Other: _____

Since the symptoms started, they have: Remained the same Gotten better Gotten worse

Rate the severity of your pain on a scale from 1 (minimal) to 10(severe):

It interferes with: Work Sleep Walking Sitting Hobbies Daily Routine Leisure

These activities are painful to perform: Sitting Standing Bending Lying Down Walking

Describe your exercise activity: None Moderate Daily Heavy

Describe your work activity: Sitting Standing Light labor Heavy labor

PAST HEALTH HISTORY

Major Surgery/Operations: _____

Major Accidents or Falls: _____

Hospitalization (Other than above): _____

Previous chiropractic care (Doctor's name and date of last visit): _____

Health conditions have you been treated for in the last 12 months: _____

More On Reverse Side →

CONDITIONS/DISEASES YOU HAVE HAD (Check all that apply)

- Pneumonia Mumps Influenza Rheumatic Fever Small Pox
- Pleurisy Polio Chicken Pox Arthritis Tuberculosis
- Diabetes Epilepsy Whooping Cough Cancer Mental Disorder
- Anemia Heart Disease Lumbago Measles Thyroid
- Eczema

Females: Date of your last period: _____ Are you pregnant? Yes No Not sure

IN THE LAST SIX MONTHS, YOU HAVE HAD (Check all that apply)

Musculoskeletal:

- Low back pain
- Pain between shoulders
- Neck pain
- Arm pain
- Joint pain/stiffness
- Walking problems
- Difficulty chewing
- Clicking jaw
- General stiffness

Genito-Urinary

- Bladder trouble
- Painful/excessive urination

General:

- Fatigue
- Allergies
- Loss of sleep
- Fever
- Headaches

Females:

- Menstrual cramping/Irregularity
- Vaginal pain
- Breast pain/lumps

Gastro-Intestinal

- Poor or excessive appetite
- Excessive thirst
- Frequent Nausea
- Vomiting
- Constipation
- Hemorrhoids
- Liver problems
- Gall bladder problems
- Weight problems
- Abdominal cramps
- Gas/Bloating after meals
- Indigestion/heartburn
- Black/bloody stool
- Colitis

EENT:

- Vision problems
- Dental problems
- Sore throat
- Ear aches
- Hearing difficulty
- Stuffed nose

Males:

- Prostrate/sexual dysfunction

Nervous System:

- Nervousness
- Numbness
- Paralysis
- Dizziness
- Forgetfulness
- Confusion
- Depression
- Fainting
- Convulsions
- Cold/tingling extremities
- Stress

CVR:

- Chest Pain
- Shortness of breath
- Blood pressure problems
- Irregular heartbeat
- Heart problems
- Lung problems
- Varicose veins
- Ankle swelling
- Stroke

Dr. William Madosky, Chiropractic Physician
2175 Big Bend Blvd., St. Louis, MO 63117 314-645-8805

PATIENT FINANCIAL AGREEMENT

I understand and agree that health and accident insurance policies are an agreement between an insurance carrier and myself. Furthermore, I understand that Dr. William Madosky and staff will prepare any necessary reports and forms to assist me in making collections from the insurance company and that any amount authorized to be paid directly to Dr. William Madosky will be credited to my account upon receipt. However, I clearly understand and agree that the 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 at this office, any outstanding charges for professional services rendered me will be immediately due and payable. Furthermore, I understand and agree that if my account becomes delinquent and requires Dr. Madosky to utilize a collection agency and/or an attorney to collect any outstanding balance, that I am responsible for all of these costs, for the collection agency, attorney, and the court costs, as well as my outstanding balance.

Print Name _____ Date _____

Signature _____ Social Security # _____

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CONSENT TO BE TREATED

Chiropractic

A Doctor of Chiropractic is a physician and a member of the healing arts concerned with the health needs of the public. The Doctor of Chiropractic gives particular attention to the relationship of the structural and neurological aspects of the body in health and disease. The Chiropractor is educated in the basic clinical sciences, as well as in other related health subjects.

It is important to recognize the difference between Chiropractic and medicine. Both may be important to your health, but for entirely different reasons. Chiropractic physicians seek to restore health through natural means without drugs or surgery. They do this by attempting to free the body of any functional or structural abnormalities of the neuromusculoskeletal system, thereby restoring the natural flow of energy in the nervous system. This enhances the body's own amazing ability to heal itself.

It is important to understand what to expect from Chiropractic services so that you, the patient, can make an informed decision as to whether it maybe of benefit to you.

Analysis and Diagnosis

The Doctor of Chiropractic must be well trained to diagnose, including, but not limited to, spinal analysis, to care for the human body in health and disease; and to consult with or refer to other health care professionals.

A Chiropractic Physician conducts an analysis to determine whether there is evidence of spinal subluxation. When such subluxations are found, Chiropractic adjustments are given to restore proper spinal alignment, giving the body its best chance to restore health. Due to the complexities of nature, no physician can promise you specific results.

With respect to Chiropractic diagnosis, it is the position of the Council on Chiropractic Education that appropriate evaluative procedures must be undertaken by the Chiropractic physician prior to initiation of patient care. The physician must do proper and necessary examination procedures, including recording of patient and family history, presenting complaint, subjective symptoms, objective findings and skeletal-biomechanical and subluxation evaluation, and when clinically necessary, such continuum reports, emotional psychological evaluation, x-ray evaluation and a diagnosis or clinical impression made therefrom.

Every patient should be mindful of their own symptoms and should secure a second physician's opinion if they have any concern as to the nature of their illness or injury.

Chiropractic Adjustments

The patient, in coming to the Chiropractor, gives permission and authority to adjust the patient in accordance with the chiropractic analysis and diagnosis. The Chiropractic adjustment usually is beneficial and seldom causes any problems.

In rare cases, underlying physical defects, deformities or pathology may render the patient susceptible to injury. Although it is uncommon, in certain cases, illness or may result from any treatment, rendered by any health care professional. Again, it is the responsibility of the patient to make it known or to learn through medical procedures whether they are suffering from latent pathological defects, illness or deformities which would otherwise not come to the attention of the Doctor of Chiropractic.

The Chiropractic physician provides a specialized health service and does not take part in the patient's medical regimen. A patient should never ask for or accept advice from a Chiropractic physician concerning the taking of prescriptive medicines. Similarly, a patient should not ask for or accept treatment from a Doctor of Chiropractic, which involves a surgical procedure or the practice of obstetrics.

Results

The purpose of Chiropractic is to promote natural health. Since there are so many variables, it is difficult to predict the time schedule or efficacy of Chiropractic procedures. The success of the Chiropractic treatment often depends upon underlying causes and conditions. Sometimes the response is phenomenal. In most cases there is a more gradual but quite satisfactory response. Occasionally, the results are mediocre or dismal. Two or more similar conditions may respond differently to the same Chiropractic care.

Many medical failures find quick relief through Chiropractic. In turn, conditions which do not respond to Chiropractic care may be treatable through medical science. The fact is, the sciences of Chiropractic and medicine may never be so exact as to provide definite answers to many problems. Both have made great strides in alleviating pain and controlling disease.

I hereby acknowledge that I have read the foregoing and understand it.

Signature of Patient or Parent/Guardian Date

Witness Date

Dr. William Madosky, Chiropractic Physician
2175 Big Bend Blvd., St. Louis, MO 63117 314-645-8805

OSHA COMPLIANCE FORM

In compliance with The Occupational Safety & Health Administration's (OSHA) regulations, and to help insure your safety and health as well as our own, we must ask if you have tested positive, or if you test positive in the future for any of the following, that you inform Dr. William Madosky.

1. Hepatitis Viruses
2. Syphilis
3. Gonorrhea
4. HIV or AIDS

My signature below indicates that I will inform Dr. William Madosky if I now have, or if in the future, test positive for any of the above.

Name _____ Date _____

Protected Health Information

Dr. William Madosky is required by law to protect your health information. Your medical records are confidential and will only be used for the purpose of treatment, payment of your bill, and healthcare operations. For example, treatment information may be shared by or with referring physicians or businesses associated with payment (such as insurance companies, attorneys, the benefit coordinator at your place of employment, etc.)

Dr. William Madosky or his staff will not provide your health information without your written consent. You may revoke your consent anytime after you have provided it. If you chose to revoke your consent, your health information can still be used to obtain payment of an outstanding balance.

Dr. William Madosky or his staff may contact you by phone or by mail. We may need to ask questions regarding your insurance or remind you of an appointment.

If you feel your privacy has been compromised and wish to file a complaint you may contact the **Department of Health and Human Services**.

Our privacy policies may change over time. A current copy of our privacy policy will be posted in our office for you to view during regular business hours.

I have read and understand the above information about my protected health information and I agree to the policy adopted by Dr, William Madosky.

Patient Name (Please Print)

Social Security Number

Patient Signature

Date

Dr. William Madosky, Chiropractic Physician
2175 Big Bend Blvd., St. Louis MO. 63117 341.644.0885

**STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF
PROTECTED HEALTH INFORMATION**

2175 Big Bend Blvd.
St. Louis, MO 63117
314-645-8805

Information to be Used or Disclosed.

The information covered by this authorization includes:
Medical Records, X-rays & MRIs w/Reports, CAT Scans, and Billing, and any additional information pertinent to the patient mentioned in this authorization

Persons Authorized to Use or Disclose information

Dr. William Madosky, 2175 Big Bend, St Louis, MO 63117

Information listed above will be used or disclosed by:

Any persons employed by the facilities listed above.

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:
Any person(s) or facilities referred to for treatment.

Expiration Date of Authorization

This authorization is effective through 01/01/14 unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization,

You may revoke or terminate this authorization by submitting a written revocation to Madosky Chiropractic. You should contact the William Madosky, DC to terminate this authorization,

Potential for Re-disclosure

Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. The privacy of this information may not be protected under the federal privacy regulations.

Signature

Name of patient (print or type)

Signature of Patient

Date

Signature of Patient Representative

Relationship of Patient Representative to Patient

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected healthy information. If you have any objections to this form, please ask to speak with Dr. William Madosky, (314) 645-8805.

Signature below is only acknowledgement that you have received, this Notice of our Privacy Practices:

Print Name _____ Signature _____ Date _____