Dr. John R. Greensfelder
Dr. Alicia M. Kovach
Chiropractor
325 Gambrills Road, Suite A
Gambrills, Maryland 21054
(410) 674-8605 ▪ fax (410) 674-8608

Health History

Patient Data

Name ____________________ Date __________ Email ____________________
Address ____________________ City ____________________ State ______ Zip______
Telephone: Home ____________________ Cell ____________________ Work ____________________
Date of Birth ___/___/___ Age _____ Sex: ☐ M ☐ F Social Security # ____________________
Marital Status: S M D W Occupation ____________________ Employer ____________________
Spouse's Name ____________________ Spouse's DOB ___/___/___ Spouse's Occupation____________________
Spouse's Employer ____________________ Referred By ____________________
Emergency Contact ____________________ Emergency Number ____________________

Current Complaints

Nature of Complaint: ☐ Automobile ☐ Work ☐ Other
Please describe ____
Have you ever had this same condition? ☐ Yes ☐ No If Yes, When? ____________________
List other practioners seen for this condition ____________________
Have you ever been under chiropractic care? ☐ Yes ☐ No If Yes, When? ____________________

Insurance Information

Insurance Company ____________________ Telephone ____________________
Cardholder's Name ____________________ Relationship to you ____________________
Cardholder's SS #____________________ ID # ____________________ Group # ____________________

Medical History

Have you been treated for any conditions in the last year? ☐ Yes ☐ No
If yes, please describe ____
Date of last physical exam ____________ Female Only: Is there a chance your pregnant ☐ Yes ☐ No
Have you had x-rays taken? ☐ Yes ☐ No If yes, where ____________________
What medications are you taking and for what conditions. (Please list dosage and amounts, etc) ____________
____
Do you suffer from any condition other than for which you are now consulting us about? ____________
____

Family History:	Diabetes	Heart	Kidney	Cancer	Back	Other	
Mother	☐	☐	☐	☐	☐	☐	____________
Father	☐	☐	☐	☐	☐	☐	____________
Brother, No. of ___	☐	☐	☐	☐	☐	☐	____________
Sister, No. of ___	☐	☐	☐	☐	☐	☐	____________

Have you ever:	Yes	No	Briefly explain
Broken any bones?	☐	☐	______
Been hospitalized?	☐	☐	______
Been in an auto accident?	☐	☐	______
Had sprains/strains?	☐	☐	______
Ever been on crutches?	☐	☐	______
Had surgery?	☐	☐	______
Ever been knocked unconscious?	☐	☐	______
Ever had a lapse of memory?	☐	☐	______
Ever had a spinal tap or injections?	☐	☐	______

Habits:	None	Light	Mod	Heavy
Alcohol	☐	☐	☐	☐
Coffee	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Sleep	☐	☐	☐	☐
Appetite	☐	☐	☐	☐
Water	☐	☐	☐	☐

	Yes	No
Do you experience pain every day?	☐	☐
Do your symptoms interfere with daily life?	☐	☐
Do you take vitamin supplements?	☐	☐
Does pain wake you up at night?	☐	☐
Are your symptoms worse during certain times for the day?	☐	☐
Do changes in weather affect your symptoms?	☐	☐
Do you wear orthotics?	☐	☐

Ever had any of the following diseases:

Please " Black Out " for Present and " X " for Previous. Leave blank if not applicable.

☐ Alcoholism ☐ Epilepsy ☐ Pleurisy
☐ Anemia ☐ Goiter ☐ Pneumonia
☐ Appendicitis ☐ Heart Disease ☐ Polio
☐ Arthritis ☐ Influenza ☐ Rheumatic Fever
☐ Cancer ☐ Lumbago ☐ Tuberculosis
☐ Chicken Pox ☐ Measles ☐ Venereal Infection
☐ Diabetes ☐ Mental Disorder ☐ Whooping Cough
☐ Eczema ☐ Mumps ☐ AIDS

GENERAL SYMPTOMS

☐ Headache ☐ Loss of Sleep
☐ Fever ☐ Fatigue
☐ Chills ☐ Nervousness
☐ Night Sweats ☐ Loss of Weight
☐ Fainting ☐ Numbness or Pain in Arms/Legs/Hands
☐ Dizziness
☐ Convulsions ☐ Allergy
☐ Neuralgia ☐ Wheezing

MUSCLES & JOINTS

☐ Weakness ☐ Twitching
☐ Stiff Neck ☐ Backache
☐ Tremors ☐ Swollen Joints
☐ Foot Trouble ☐ Pain between Shoulders
☐ Hernia ☐ Spinal Curvature

GASTRO-INTESTINAL

☐ Poor Appetite ☐ Poor Digestion
☐ Excessive Hungry ☐ Belching/Gas
☐ Nausea ☐Vomiting
☐ Vomiting Blood ☐ Pain over Stomach
☐ Constipation ☐ Jaundice
☐ Diarrhea ☐ Hemorrhoids (Piles)
☐ Liver Trouble ☐ Gall Bladder Trouble

CARDIO-VASCULAR

☐ Rapid Heart ☐ Slow Heart
☐ High Blood Pressure ☐ Low Blood Pressure
☐ Pain over Heart ☐ Previous Heart Trouble
☐ Swelling Ankles ☐ Poor Circulation
☐ Varicose Veins ☐ Strokes

EYE/EAR/NOSE/THROAT

☐ Poor Vision ☐ Crossed Eyes ☐ Pain in Eyes
☐ Deafness ☐ Earache ☐ Ear Noises
☐ Sinus Trouble ☐ Nose Bleeds ☐ Sore Throats
☐ Hoarseness ☐ Hay Fever ☐ Enlarged Thyroid
☐ Frequent Colds ☐ Tonsillitis ☐ Asthma ☐ Bronchitis

SKIN OR ALLERGIES

☐ Eczema ☐ Itching
☐ Bruise Easily ☐ Dryness
☐ Sensitive Skin ☐ Hives or Allergy

RESPIRATORY

- ☐ Chronic Cough
- ☐ Spitting Phlegm
- ☐ Difficulty Breathing
- ☐Spitting Blood
- ☐ Chest Pain
- ☐ Bronchitis

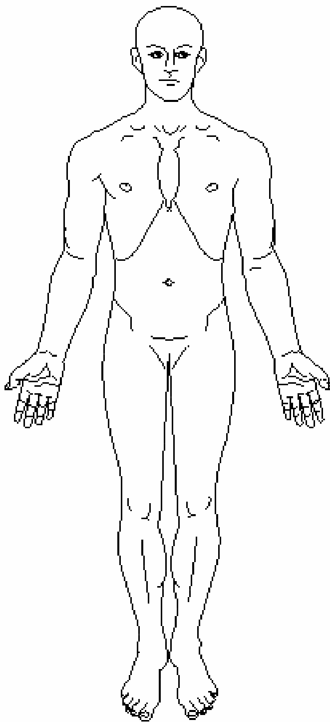
GENITO-URINARY

- ☐ Frequent Urination
- ☐ Blood in Urine
- ☐ Kidney Stones
- ☐ Painful Urination
- ☐ Kidney Infection
- ☐ Prostate Trouble

FOR WOMEN ONLY

- ☐ Painful Periods
- ☐ Hot Flashes
- ☐ Excessive Flow
- ☐ Cramps/Backaches
- ☐ Irregular Cycles
- ☐ Miscarriage
- ☐ Vaginal Discharge
- ☐ Pregnant at this time

Current Complaints (Continued)



Severity of Pain

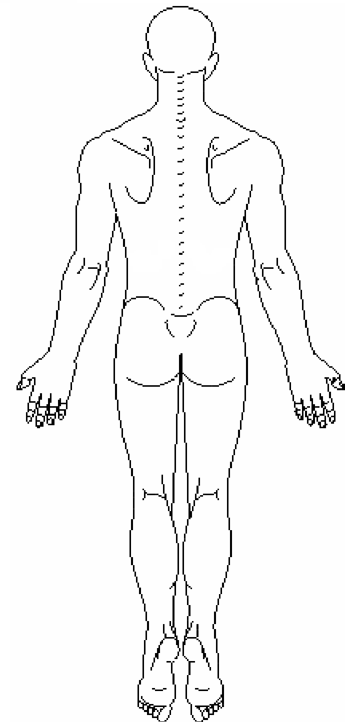
List region of pain and circle severity number.
[1 = Least, 10 = Greatest]

Ex. ______Neck______________
1 2 3 4 5 6 7 8 9 10

Mark Pain Area

A = Ache S = Stabbing
B = Burning P = Pins & Needles
N = Numbness O = Other

1. ________________________
1 2 3 4 5 6 7 8 9 10
2. ________________________
1 2 3 4 5 6 7 8 9 10
3. ________________________
1 2 3 4 5 6 7 8 9 10
4. ________________________
1 2 3 4 5 6 7 8 9 10
5. ________________________
1 2 3 4 5 6 7 8 9 10



Please mark area of pain on the drawing using the code listed above.

Certification and Assignment

I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. Furthermore, I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in making collection from the insurance company, and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt. However, I clearly understand and agree that all services rendered me are charged directly to me, and that I am personally responsible for that 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.

I hereby authorize the Doctor to examine and treat my conditions as he deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. It is understood and agreed the amount paid the Doctor for X-rays is for examination only and the X-ray negatives will remain the property of this office, being on file where they may be seen at any time while a patient of this office. The patient also agrees that he/she is responsible for all the bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

Patient's Signature X ______________________________________ **Date** ______________

Odenton Chiropractic Patient Information Usage Agreement

The 1996 HIPAA Legislation contains provisions that prohibit the disclosure of patient information; compliance "to the Letter" of the act would create a highly impersonal atmosphere and longer visit times in the office. Use of certain items of your personal information within the space of the office will help us preserve the family atmosphere and keep your visits on schedule.

In order to make my visits to the office as easy as possible, I agree to let Odenton Chiropractic doctors and staff use limited personal information for the following purposes:
(please check the "yes" box for all items that you agree to.)

Call me by name while in the office.	Yes ☐	No ☐
Have a patient sign-in sheet that will be seen by other patients	Yes ☐	No ☐
Have a personal discussion with me in common areas of the office	Yes ☐	No ☐
Call me regarding appointments at the telephone number(s) listed in my records	Yes ☐	No ☐
Leave a message on an answering machine or with a family member regarding appointments, at the telephone number(s) listed in my records	Yes ☐	No ☐
Leave a message at my place(s) of employment, regarding appointments, at the telephone number(s) listed in my records	Yes ☐	No ☐
Call to request test results on my behalf from imaging centers, labs, or other referred specialists	Yes ☐	No ☐

________________________ Print Name

________________________ Signature

____________ Date

Pleases supply alternate instructions for any of the items checked "no" in the following space

Odenton Chiropractic Financial Policy

Thank you for choosing us as your health care provider. The following is our financial policy. Our main concern is that you receive the proper and optimal treatments needed to restore you heath. If you have any questions or concerns about our payment policy please calls the office.

We ask that all patients read and sign our Financial Policy as well as complete our Patient Information Form prior to seeing the doctor.

Payment for services is due at the time services are rendered. We accept cash, check and credit card for your convenience. We will be happy to process your insurance claim for you; please bring forms if appropriate.

In special instance, we accept assignment of insurance benefits. However, you must understand that:

1. Your insurance policy is a contract between you, your employer and your insurance company. OUR relationship is with you, not your insurance company.
2. All charges are your responsibility whether or not your insurance company pays. Not all services are a covered benefit in all insurance contracts. A telephone inquiry on your behalf is a courtesy call and as stated by the representative, this benefit quote is not a guarantee of benefits.
3. In cases where your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring us the referral. If there is no referral present at the time of your chiropractic visit, it is your responsibility to comber the professional fees for the visit.
4. Fees for these services along with unpaid deductibles and co-payments are due at the time of treatment.
5. We accept personal checks. However, a $25.00 fee applies for all returned checks.
6. In cases where financial payment are arranged, a late charge of $5.00/ month will be assessed on all over due balances beginning on the 60th day.

Please note that unless canceled at least 24 hours in advance, there is a charge for missed appointments at the normal office visit rate (not covered by insurance). Please call if you have to reschedule.

We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Patient Signature______________________________ **Date**______________