# David Silbert, DC

*Silbert Chiropractic Clinic, P.C.*
2258 Eureka Road | Wyandotte, Michigan 48192 | Telephone: (734) 285-0020 | Fax: (734) 285-0512

Date: _____ Patient #: _____

## *Patient Information*

Patient Name: _____ Preferred Name: _____
Marital Status: Single Married Divorced Widowed Separated Gender: Male Female
If married, spouse's name: _____ Date of Birth: ____ / ____ / ____
Social Security #: _____ - _____ - _____ Email: _____
Address: _____
City: _____
Home Phone: (____) ____ - _____ Work Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____
Occupation: _____ Employer/School Name: _____
Physician: _____ City: _____ State: _____
In case of emergency, contact: _____ Relationship: _____ Phone: (____) ____ - _____
Payment in full is due at each appointment. For your convenience, we offer the following methods of payment: Cash | Check | Credit Card

## *Insurance Information*

**Primary Insurance**
Insurance Co. Name: _____ Phone: (____) ____ - _____
Insured's Name: _____ Relationship to Patient: _____
Insured's ID #: _____ Insured's Date of Birth: ____ / ____ / ____
Insured's Employer: _____ Employer Phone: (____) ____ - _____
Group #: _____
**Secondary Insurance** (If applicable, please fill out)
Insurance Co. Name: _____ Phone: (____) ____ - _____
Insured's Name: _____ Relationship to Patient: _____
Insured's ID #: _____ Insured's Date of Birth: ____ / ____ / ____
Insured's Employer: _____ Employer Phone: (____) ____ - _____
Group #: _____

## *Authorization & Release*

You are authorized to release any information you deem appropriate concerning my physical condition to any insurance company, attorney, or adjuster in order to process any claim for reimbursement of charges incurred by me as a result of professional services rendered by you and/or any designated associated and I hereby release you of any consequence thereof. My attorney and/or insurance company are hereby requested to pay direct to the doctor listed below, any monies due him on account, the same to be deducted from any settlement made on my behalf. I understand that if it is determined either (A.) That there is no insurance company obligated to pay for services, or if the insurance company involved refuses to acknowledge an assignment to the doctor; or make other provisions for the protection of the interest of the doctor; or (B.) If a liability claim exists and my attorney refuses to agree to protect the interest of the doctor, or if I have not engaged the service of an attorney: then payment of the services rendered by David Silbert, D.C. and/or any designated associate will be made on current basis and my bill paid in full as soon as my liability claim is settled or the passage of three months from my last treatment, whichever occurs first. I understand that there is a $35.00 fee if an outside collection agency is utilized. I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved as the original copy. I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his staff responsible for any errors of omissions that I have made in the completion of this form.

_____ ____ / ____ / ____ _____
Signature Date (If minor, parent/guardian signature)

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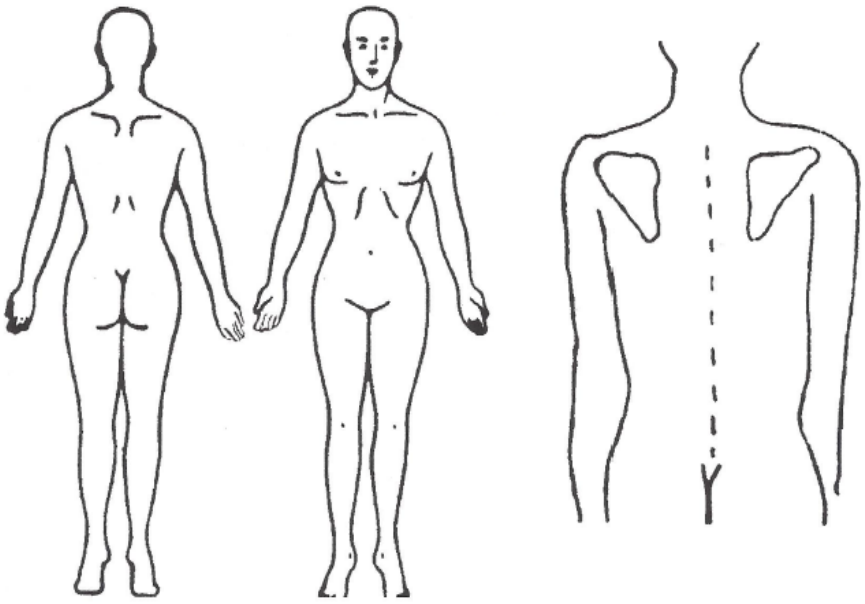
**Patient Pain Profile**

1. Please indicate where your pain is located. Indicate the appropriate location using the SYMBOL that best describes the discomfort you are presently experiencing.

A= Ache
B= Burning
D= Dullness
N= Numbness
P= Pins & Needles
R= Radiation
S= Stabbing



2. Describe your symptoms and/or pain. (Where do you hurt?) _____
_____
3. Type of Pain (Circle one or more)
   - A. Ache
   - B. Burning
   - C. Dullness
   - D. Numbness
   - E. Pins & Needles
   - F. Radiation
   - G. Stabbing
   - H. Other _____
4. Please list any associated symptoms (i.e. leg pain, fatigue irritability, headache, difficulty sleeping, etc.)_____
5. Please mark your pain level on the 1 to 10 scale with a vertical line, with 0 being "no pain" and 10 being the maximum pain you can imagine.

| | **No Pain** |
|---|---|
| NOW | 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10 |
| AT WORST | 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10 |
| AT BEST | 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10 |
| AVERAGE | 0 . . . 1 . . . 2 . . . 3 . . . 4 . . . 5 . . . 6 . . . 7 . . . 8 . . . 9 . . . 10 |

6. Did the problem start a) Gradually___ or b) Suddenly ___?
7. Describe **how** it began. What started your pain – any trauma or unusual events? _____
   _____
8. **When** did your pain begin? _____
9. What % of the time are you in pain? ___ 0-25% ___25-50% ___50-75% ___75-100%
10. Is the problem constant ____ or off and on ____? How long does it last? _____
11. Is pain worse in the morning? ____, late in the day ____, at night ____, or other
    _____
12. Compared to when it started, is your pain better ____ worse ____ or the same ____?
13. What other treatment have you had? _____
14. What makes the pain better (heat, ice, medication, lying down, moving, other)?
    _____
15. How does this problem affect you, specifically your lifestyle, recreation, work, relationship? What can't you do comfortably anymore? _____
    _____
16. Have you had problems with this area before? ____ Describe them and how long you've had them. _____
    _____
17. List any medication(s) you are now taking: _____
    _____
18. Please list any pertinent surgeries or hospitalizations: _____
    _____
19. Please list any pertinent surgeries or hospitalizations: _____
    _____
20. Are there any secondary problems you want to talk to the Doctor about? _____
    _____
21. Any known birth defects or deformities? _____
22. Traumas (Give date of trauma and body part involved)
    - Vehicle Accidents _____
    - Work Injuries _____
    - Sports Injuries _____
    - Slip/Fall Injuries, Lifting Injuries _____
    - Concussions _____
    - Fracture/Dislocations _____
    - Birth Trauma _____
    - Childhood physical/sexual abuse _____
    - Other injuries _____

# Activities of Daily Living (ADL) Information

**Condition's Effect on Daily Activities**

- □ **No Effect**
- □ **Mild** Painful (Can do)
- □ **Mod** Painful (limited ability)
- □ **Mod/Sev** Limited Duty
- □ **Severe** No Limited Duty
- □ **Severe** (can't do = limited duty)

**Please answer the following questions based on the following measurement scale:**

- **No Effect**
- **Moderate = Painful**
- **Mild = Painful (Can do)**
- **Severe = Unable to perform**

**Please check the answers that apply:**

| | | | | |
|---|---|---|---|---|
| Bending: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Care – Inferm Family: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Carrying Groceries: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Change Position – Sit – Stand: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Climb Stairs: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Driving: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Extended Computer Use: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Feeding: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Household Chores: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Kneeling: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Lift Children: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Lifting: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Pet Care: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Reading (Concentration): | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Self Care – Bathing: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Self Care – Dressing: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Self Care – Shaving: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Sleep: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Static (constant) Sitting: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Static (constant) Standing: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Walking: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| Yard Work: | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |

**Recreational Activity: Effects of Current Condition on Performance**

| | | | | |
|---|---|---|---|---|
| _____ | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| _____ | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |
| _____ | □ **No Effect** | □ **Mild** | □ **Moderate** | □ **Severe** |

# SILBERT CHIROPRACTIC CLINIC P.C. MEDICAL HISTORY
# REVIEW OF SYSTEMS FORM

DATE:_____ NAME:_____ DATE OF BIRTH:_____

__MARRIED__SINGLE__DIVORCED__WIDOWED; OCCUPATION:_____

NO. OF CHILDREN:__ TOBACCO USE: YES/NO HOW MUCH? ___/DAY HOW LONG? DATE QUIT: _____

ALCOHOL USE: YES/NO HOW MUCH? ___/DAY CAFFEINE (COFFEE, TEA, COLAS) PER DAY: _____

**REVIEW OF SYSTEMS-PLEASE CIRCLE EACH ITEM OR "NONE" AS THEY RELATE TO YOUR HEALTH**

**CONSTITUTIONAL** NONE
Fatigue
Fever

**MUSCULOSKELETAL** NONE
Osteoporosis
Arthritis
Joint Pain
Other:_____

**NEUROLOGICAL** NONE
Anxiety
Headaches
Dizziness/Vertigo
Memory Loss
Numbness
Seizures
Other:_____

**EYES** NONE
Glasses/Contacts
Double Vision
Cataracts
Other:_____

**EAR, NOSE, THROAT** NONE
Difficulty Hearing
Ringing in Ears
Sinus Trouble
Other:_____

**ALLERGIES/IMMUNE** NONE
Hives/Eczema
Hay Fever
Other:_____

**CARDIOVASCULAR** NONE
Chest Pain
Shortness of Breath
Stroke
Murmur
Palpitations
Heart Disease
High Cholesterol
High Blood Pressure
Fainting Spells
Dizziness
Difficulty Laying Flat
Swelling Ankles
Other:_____

**RESPIRATORY** NONE
Asthma
Cough
Coughing Blood
Wheezing
Chills
Other:_____

**ENDOCRINE** NONE
Diabetes
Weight Loss/Gain
Loss of Hair
Heat/Cold Intolerance
Other:_____

**MENTAL** NONE
Depression
Alcohol/Substance Abuse
Other:_____

**GASTROINTESTINAL** NONE
Heartburn/Reflux
Nausea/Vomiting
Constipation
Diarrhea
Black/Bloody Stools
Changes in BM
Abdominal Pain
Jaundice (Yellowish Skin)
Other:_____

**HEMATOLOGY/LYMPH** NONE
Bruise Easy
Gums Bleed Easy
Enlarged Glands
Other:_____

**SKIN** NONE
Rash/Sores
Itching/Burning
Dryness
Other:_____

**GENITOURINARY** NONE
Burning/Frequency
Blood in Urine
Incontinence
Other:_____

**OTHER KNOWN CONDITIONS**
_____
_____
_____
_____

**PAST SURGICAL HISTORY:** (PLEASE INCLUDE DATES AS BEST YOU CAN)

_____
_____
_____

**PAST OR PRESENT ILLNESSESS OF YOUR FAMILY: (CIRCLE ALL THAT APPLY)**

| | | |
|---|---|---|
| ALCOHOLISM | HIGH BLOOD PRESSURE | OSTEOPOROSIS |
| ANEMIA | KIDNEY DISEASE | PHLEBITIS |
| ASTHMA | LIVER DISEASE | RHEUMATIC ARTHRITIS |
| CANCER/TUMOR | HEPATITIS | STROKE |
| DIABETES | HIGH CHOLESTEROL | THYROID DISEASE |
| DEPRESSION | HIV/IMMUNE DISEASE | TUBERCULOSIS / TB |
| EPILEPSY/SEIZURES | LUNG DISEASE | ULCER IN GI TRACT |
| GLAUCOMA | MENTAL ILLNESS | OTHER: |
| HEART DISEASE | OSTEOARTHRITIS | |

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## Assignment of Benefits

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to David Silbert, D.C., and hereafter to be referred to in this document as Silbert Chiropractic, P.C., for all chiropractic services, rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance.

## Authorization to Release Information

I hereby authorize Silbert Chiropractic, P.C. to: (1) release any information necessary to insurance carriers regarding my illness and treatments;
(2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of my lifetime. This order will remain in effect until revoked by me in writing.

I have requested chiropractic services from Silbert Chiropractic, P.C. on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered, unless other arrangements have been made in advance with our business manager, and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

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**Consent for Purpose of Treatment, Payment and Healthcare Operations**

I acknowledge that SILBERT CHIROPRACTIC CLINIC P.C. "Notice of Privacy Practices" has been provided to me.

I understand I have a right to review SILBERT CHIROPRACTIC CLINIC P.C. Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in a performance of health care operations of SILBERT CHIROPRACTIC CLINIC P.C. The Notice is also provided on request at the main administration desk of this practice. Notice of Privacy Practices also describes my rights and SILBERT CHIROPRACTIC CLINIC P.C. duties with respect to my protected health information.

SILBERT CHIROPRACTIC CLINIC P.C. reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of Privacy Practices by calling the office and requesting a revise copy by sent in the mail or asking for one at the time of my next appointment.

_____ ___ / ___ / ___
(Signature of Patient or Personal Representative) (Date)

_____ ___ / ___ / ___
(Name of Patient or Personal Representative) (Date)

_____ ___ / ___ / ___
(Description of Personal Representative Authority) (Date)

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## What to expect after your first treatment

Most of the time, you will feel better after your first treatment. You probably won't feel 100% but you may have a greater sense of ease and ability to move more freely with decreased pain. If you have been in pain for longer than a few days then it usually takes longer to get relief.

Keep in mind your body is adapting to new positioning, alignment and freedom. The first night or the next day after the first treatment symptoms that you came in with may increase - occasionally dramatically. This reaction happens to about 30% of our patients and it is hard to predict to whom this will happen. Within 24-48 hours, you will usually start to feel better.

If you do have a negative reaction to the first treatment and it is not diminishing by the end of the second day, please call us. We should see you as soon as possible if the pain is not diminishing. It is often simple to resolve this type of continuing reaction with the right treatment.

Even if you feel better, it is important to use common sense, do your exercises and choose the right level of activity to support your healing. In other words, don't over do it! Small movements are generally better than none, and we will teach you correct movement/exercise patterns during your visits here.

If you are still hurting, ice is almost always safe and often gives good temporary relief. Use ice for 15-20 minutes, at least until the area becomes numb. You can use ice frequently up to once per hour. You can use an ice gel pack, a sack of frozen peas or corn, a zip-lock bag filled with ice cubes or ice cubes and water. Try to keep the rest of your body warm and comfortable while you are icing. The coldness may initially burn or hurt but should help block the pain by the time you are numb. Use a thin layer of cotton between your skin and the ice bag to prevent an ice burn to your skin.

**Please let us know before you leave the office if you are feeling worse than when you came in.**

I have read and understand the above information.

_____ _____

Signature Date

# FUTURE APPOINTMENT METHOD

TO OUR PATIENTS:

APPOINTMENTS CAN BE MADE BY TEXT OR EMAIL IF WE HAVE YOUR CELL PHONE NUMBER AND/OR EMAIL TO RESPOND.

PLEASE INDICATE YOUR PREFERENCE ALONG WITH YOUR CELL PHONE NUMBER AND/OR EMAIL ADDRESS.

THANK YOU!

NAME_____

I WOULD PREFER TO RECEIVE MESSAGES BY:

☐ TEXT MESSAGE.

MY CELL PHONE NUMBER IS:_____

MY SERVICE PROVIDER IS:_____

☐ EMAIL MESSAGE.

MY EMAIL ADDRESS IS:_____