Welcome

CARUSO CHIROPRACTIC CLINIC

We are pleased to welcome you to our practice. To save time and allow us to better serve you, please complete all the information required. If you have any questions, we'll be happy to help.

TODAYS DATE:

1. Name (Last, First, Middle Initial)	2. Sex □ M □ F	3. Social Security #	4. Age	5. Date of Birth

6. Address City State Zip	7. E-mail Address

8. Home Telephone	9. Cell Phone & Carrier	10. Work Phone	11. Which phone would you like to be contact on? □ Home □ Cell □ Work

12. Occupation	13. Employer	14. Employer's Address

15. Marital Status □ Single □ Married	16. Name of Spouse	17. Does spouse have any health problems?

18. # of Children	19. Name(s) & Age(s) of Children	20. Do your children have any health problems?

21. Name and telephone # of Emergency Contact	22. Do you have health insurance? □ YES □ NO Company's Name:

23. Referred by:	24. Have you had chiropractic care before? □ YES □ NO Where? When? Results? □Great □Good □Fair □Mixed □Poor	25. Are you possibly Pregnant? □ YES □ MAYBE □ NO Due Date _____

26. Have you ever had any accidents, injuries, or major falls? □ YES □ NO	Month, Year	Type	Describe Injury

27. Have you ever had any surgery or been hospitalized? □ YES □ NO	Month, Year	Type	Describe Injury

28. Are you currently taking any medication? □ YES □ NO	Name	Dosage	Reason for taking it

29. Are you currently taking any Nutritional Supplements? □ YES □ NO	Name	Dosage	Reason for taking it

Health History

Check any of the following conditions which you have had within the last year.

MUSCULO-SKELETAL
- ☐ Arthritis
- ☐ Arms/Hands Pain
- ☐ Hip Pain
- ☐ Jaw Problems
- ☐ Joints Pain
- ☐ Legs/Feet Pain
- ☐ Low Back Pain
- ☐ Mid Back Pain
- ☐ Neck Pain
- ☐ Osteoporosis
- ☐ Shoulder Pain/Tightness
- ☐ Stiffness

NERVOUS
- ☐ Face Twitching
- ☐ Fainting
- ☐ Nervousness
- ☐ Numbness/Tingling
- ☐ Pinched Nerve
- ☐ Seizures/Convulsions
- ☐ Tremors

FEMALE (ONLY)
- ☐ Breast Pain/Lumps
- ☐ Menstrual Cramps
- ☐ Menstrual Irregularity
- ☐ Vaginal Pain/Infections

C-V-R
- ☐ Ankle Swelling
- ☐ Asthma
- ☐ Blood Pressure Problems
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ High Cholesterol
- ☐ Shortness of Breath

GASTRO-INTESTINAL
- ☐ Abdominal Pain/Cramps
- ☐ Black/Bloody Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Frequent Nausea/Vomiting
- ☐ Heartburns
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Poor Appetite
- ☐ Ulcers

GENITO-URINARY
- ☐ Bed Wetting
- ☐ Bladder Problems
- ☐ Discolored Urine
- ☐ Excessive Urination
- ☐ Painful/Burning urination

EENT
- ☐ Ear/Hearing Problems
- ☐ Ear Infections
- ☐ Eye/Vision Problems
- ☐ Nose/Smelling Problems
- ☐ Sinus Problems
- ☐ Throat Problems

SKIN
- ☐ Itching/Rash
- ☐ Skin Problems
- ☐ Tumors/Cysts/Lumps

GENERAL
- ☐ Allergies
- ☐ Cold Sweats
- ☐ Depression
- ☐ Dizziness
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Headaches
- ☐ Memory Problems
- ☐ Sudden Loss of Weight
- ☐ Swelling

MALE (ONLY)
- ☐ Genital Problems
- ☐ Prostate Problems

Check any of the following diseases which you have had in your life.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Bulimia
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Disc Herniation
- ☐ Gout
- ☐ Hayfever
- ☐ Heart Problems
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Lung Problems
- ☐ Measles
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Paralysis
- ☐ Pneumonia
- ☐ Polio
- ☐ Shingles
- ☐ Stroke
- ☐ Suicide Attempt
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Venereal Disease
- ☐ Whooping Cough

Family History

Check the following family members that had any of the diseases mentioned above.

- ☐ Father: _____
- ☐ Mother: _____
- ☐ Brother: _____
- ☐ Sister: _____
- ☐ Spouse: _____
- ☐ Child: _____
- ☐ Uncles/Aunts: _____
- ☐ Grandparents: _____

Patient Name: _____ Date: _____

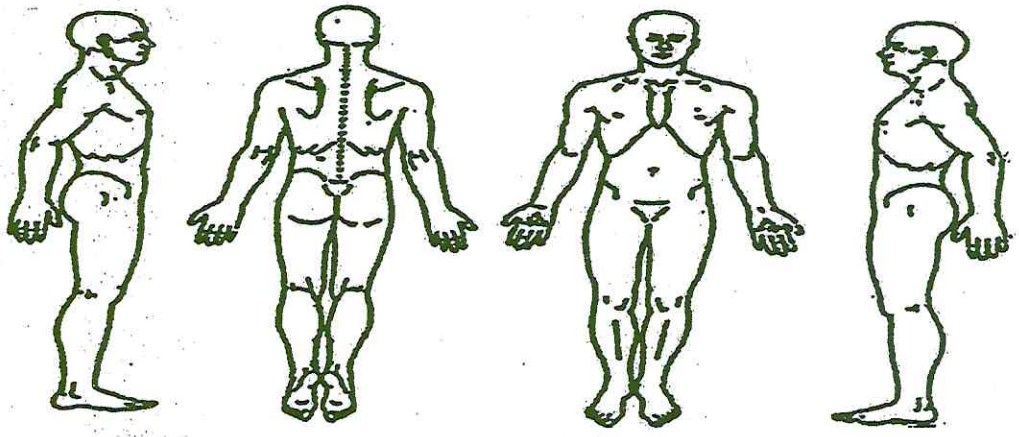
Your Current Condition

Patient Name: _____ Date: _____

1. Chief complaint? _____

2. Is today's problem caused by: □ Auto Accident □ Workman's Compensation □ Other

3. Indicate on the drawings below where you have pain/symptoms



4. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

5. How would you describe the type of pain?

□ Sharp □ Numb
□ Dull □ Tingly
□ Diffuse □ Sharp with motion
□ Achy □ Shooting with motion
□ Burning □ Stabbing with motion
□ Shooting □ Electric like with motion
□ Stiff □ Other: _____

6. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

7. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

8. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

9. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

10. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Primary Care Physician
□ ER physician □ Orthopedist □ Other: _____
□ Massage Therapist □ Physical Therapist □ No one

11. How long have you had this problem? _____

12. How do you think your problem began? _____

13. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

14. What aggravates your problem? _____

15. What alleviates your problem? _____

16. What concerns you the most about your problem; what does it prevent you from doing? _____

Patient Name: _____ Date: _____

17. What is your: Height_____ **Weight** _____

18. How would you rate your overall Health? □ Excellent □ Very Good □ Good □ Fair □ Poor

19. What type of exercise do you do? □ Strenuous □ Moderate □ Light □ None

20. What activities do you do at work?

□ **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 of the day	□ A little of the day

21. What activities do you do outside of work? _____

_____

22. Have you ever been hospitalized? □ No □ Yes

If yes, why _____

23. Primary Care Physician name, phone and address: _____

_____

23. Anything else pertinent to your visit today?_____

I certify that I have read, understood, and answered the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health.

X_____ **Date**

Signature of Patient (or parent if minor)

Insurance Company Name _____

Primary Insured Person _____ Primary Insured Date of Birth _____

Primary Insured Gender: □ Male □ Female How is patient related to Primary Insured? _____

Authorization for treatment and billing

I hereby authorize Dr. Sam Caruso, and whomever he may designate as his assistant, to administer treatment to me or my dependents as he so deems necessary.

I authorize Caruso Chiropractic Clinic to release any information concerning my condition to any insurance company, attorney, or health practitioners. I authorize direct payment to Caruso Chiropractic Clinic for any sum that I owe now or in the future, from any insurance company that is obligated to reimburse me for charges incurred in your office, or my attorney out of the proceeds of my settlement. A photocopy of this form is acceptable for payment. I herby assign and give to Caruso Chiropractic Clinic the right to take action against any insurance company that is obligated by contract to make payment to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents, and pay it within a 90 day period. I understand that in the event my account is past due, I will be charged and I will be responsible for an additional $20.00 fee.

X_____ **Date**

Signature of Patient (or parent if minor)

Consent for Release of Information

I understand under the HIPAA guidelines, my personal account and medical information may not be released to anyone without my consent. I am allowing any/all of my account and medical information to be given to the persons named below when requested by the named persons below.

_____

_____

X_____ **Date**

Signature of Patient (or parent of minor)

Patient Name: _____ Date: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I am aware of the Caruso Chiropractic Clinic, P.C. Notice of Privacy Practices and if I choose to obtain a written copy I can do so by logging on to www.carusochiropractic.com

X_____

Signature of Patient (or parent of minor) **Date**

_____

Signature of Witness Date