

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 <input type="checkbox"/> M <input type="checkbox"/> 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? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work	
12. Occupation	13. Employer	14. Employer's Address			
15. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO Company's Name:		
23. Referred by:		24. Have you had chiropractic care before? <input type="checkbox"/> YES <input type="checkbox"/> NO Where? When? Results? <input type="checkbox"/> Great <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Mixed <input type="checkbox"/> Poor		25. Are you possibly Pregnant? <input type="checkbox"/> YES <input type="checkbox"/> MAYBE <input type="checkbox"/> NO Due Date _____	
26. Have you ever had any accidents, injuries, or major falls? <input type="checkbox"/> YES <input type="checkbox"/> NO		Month, Year	Type	Describe Injury	
27. Have you ever had any surgery or been hospitalized? <input type="checkbox"/> YES <input type="checkbox"/> NO		Month, Year	Type	Describe Injury	
28. Are you currently taking any medication? <input type="checkbox"/> YES <input type="checkbox"/> NO		Name	Dosage	Reason for taking it	
29. Are you currently taking any Nutritional Supplements? <input type="checkbox"/> YES <input type="checkbox"/> 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: _____

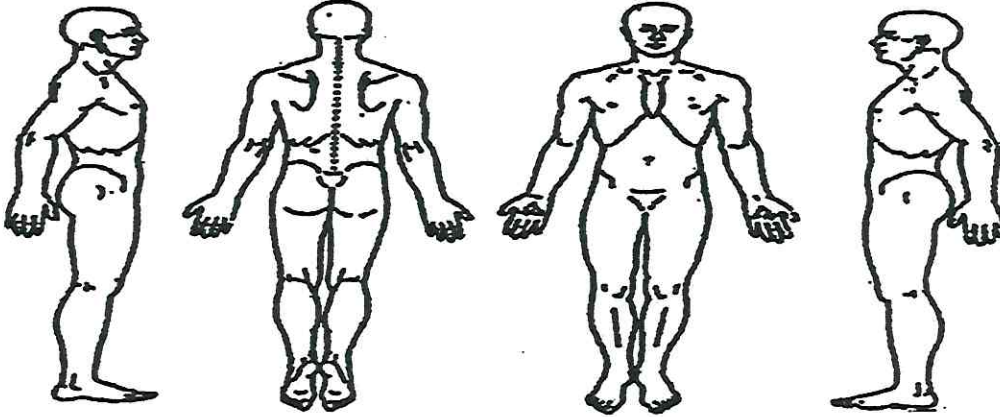
Your Current Condition

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?

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Sharp | <input type="checkbox"/> Numb |
| <input type="checkbox"/> Dull | <input type="checkbox"/> Tingly |
| <input type="checkbox"/> Diffuse | <input type="checkbox"/> Sharp with motion |
| <input type="checkbox"/> Achy | <input type="checkbox"/> Shooting with motion |
| <input type="checkbox"/> Burning | <input type="checkbox"/> Stabbing with motion |
| <input type="checkbox"/> Shooting | <input type="checkbox"/> Electric like with motion |
| <input type="checkbox"/> Stiff | <input type="checkbox"/> 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?

- | | | |
|--|---|---|
| <input type="checkbox"/> Chiropractor | <input type="checkbox"/> Neurologist | <input type="checkbox"/> Primary Care Physician |
| <input type="checkbox"/> ER physician | <input type="checkbox"/> Orthopedist | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Massage Therapist | <input type="checkbox"/> Physical Therapist | <input type="checkbox"/> 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?

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Sit: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Stand: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> Computer work: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half the day | <input type="checkbox"/> A little of the day |
| <input type="checkbox"/> On the phone: | <input type="checkbox"/> Most of the day | <input type="checkbox"/> Half of the day | <input type="checkbox"/> 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 _____
Signature of Patient (or parent if minor) _____ Date _____

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 & Dr. Bradley Sabo or whichever Dr/ Chiropractic assistant they may designate to administer treatment to me or my dependents they deem 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 hereby 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 _____
Signature of Patient (or parent if minor) _____ Date _____

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

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